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
	IL6008528	A. BUILDING: ______ B. WING ______	C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE SENIOR LIVING	1901 13TH STREET HERRIN, IL 62948

(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 Complaint Investigations: 2252508/IL145251 2252619/IL145385 2253117/IL146037	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 300.1210 c) 300.1210 d)2) 300.1210 d)3) 300.1210 d)5) 300.1220 b)2) 300.1220 b)7) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. 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	S9999		

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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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

7) Coordinating the care and services provided to residents in the nursing facility.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on interview, observation, and record review the facility failed to identify, monitor, and

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treat a pressure wound for 3 (R1, R3, R4) of 3 residents reviewed for pressure ulcers in a sample of 7.

This failure resulted in R3's wound declining to an unstageable large sacral decubitus ulcer, necrotizing soft tissue infection, and sepsis over the course of 6 weeks, until hospitalized on 3/25/22 for abnormal labs as documented by the facility. R3 underwent a wide debridement of necrotizing soft tissue infection of sacrum and bilateral gluteal regions, placed on a wound vac, comfort care, hospice, and subsequently passed away in the hospital on 4/06/22, due to sepsis with multi-organ failure.

The findings include:

1. R3's Admission Record profile sheet documents admission to this facility on 12/07/20, to include the following diagnoses: Chronic Obstructive Pulmonary Disease, Unilateral Pulmonary Emphysema, Major Depressive Disorder, Anemia, Osteoarthritis Unspecified Knee, Anorexia, and Insomnia. Additional diagnoses include left artificial hip joint (2/17/21), bipolar II disorder (2/22/21), anxiety disorder (2/24/21), acute and chronic respiratory failure with hypoxia (2/15/22), and pneumonia (2/15/22).

R3's most recent quarterly Minimum Data Set (MDS), dated 2/22/22, documents R3 is cognitively intact, with a BIMS (Brief Interview for Mental Status of 14, and assessed to require the following - extensive two plus person physical assist for bed mobility, dressing, transfer and indicates transfer occurred only once or twice in a 7-day period; walking in room or corridor did not occur; one person physical assist with locomotion

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S9999	Continued From page 4 on and off unit and occurred only once or twice in a 7-day period; supervision and one person physical assist with eating; and extensive one person physical assist with toilet use and personal hygiene. R3's care plan, dated 12/08/20, updated on 4/14/21, documents an intervention under the focus area for falls R3 requires a mechanical lift with two person-assist for transfers, date Initiated/created: 3/22/2021. Also included in R3's care plan: Focus Area - R3 is at risk for pressure injury development related to impaired mobility; 3/2/2022 wound left buttock; 3/25/2022 wound to right lower back revised on 3/31/22. Goal - R3 will have intact skin, free of redness, blisters, or discoloration by/through review date, revised 12/09/21, target date05/25/22. Interventions in part - Administer treatments as ordered and monitor for effectiveness. Requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing, date initiated/created: 3/31/2022; Turn every 1-hour, date initiated/created: 3/21/2022 by: V30 (Licensed Practical Nurse - LPN/Wound Nurse); low air-loss mattress, date initiated/created: 1/21/2021; Needs assistance to turn/reposition approximately every 2 hours, more often as needed or requested, date initiated/created: 12/29/2020; Obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated, date initiated/created: 3/22/2021; Provide pressure reducing mattress to bed/ pad to wheelchair, date initiated/created: 12/29/2020; Use lifting device, draw sheet, etcetera to reduce friction, date initiated/created: 12/29/2020; Weekly skin check. Notify nurse immediately of any new areas of skin	S9999		

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breakdown: redness, blisters, bruises, or discoloration noted during bathing or daily care, date initiated/created: 12/08/2020.

R3's cumulative Order Review Report includes the following - skin checks with an original start date upon admission of 12/08/20, end date 2/11/22.

R3's January 2022 TAR (Treatment Administration Record) documents - skin checks (Monday and Thursday) I = Intact; N = New; W = Wound every day-shift Monday, Thursday, start date 12/10/20, d/c (discontinue) date 2/11/22. R3's skin checks were completed on 1/06, 1/10, 1/13, 1/20, 1/24, and 1/27, all indicating intact skin. There was no skin check documented as being performed on 1/03, 1/17, 1/24, or 1/31. 4 out of 9 skin check days were not documented as completed.

R3's January 2022 TAR also documents - zinc oxide apply to both buttocks topically every shift for wound prevention. Cleans with wound cleanser and pat dry. Apply z-guard every shift (1st shift 6A-6P and 2nd shift 6P-6A), start date 3/17/21, d/c date 2/07/22. This TAR documents preventative treatment was provided on one shift only, instead of both shifts, as ordered - 1/01; 1/02; 1/5; 1/07; 1/09 - 1/12; 1/14 - 1/19; 1/23; 1/25; 1/26; 1/28, and 1/29. This TAR is completely blank on 1/03; 1/17; 1/21; 1/22; 1/24; and 1/31. R3's January 2022 TAR documents z-guard not documented as applied as ordered 30 out of 62 application times on 1/01, 1/02, 1/03, 1/05, 1/07, 1/09-1/12, 1/14-1/19, 1/21-1/26, 1/28, 1/29, and 1/31.

On 4/07/22 at 1:49 PM, when asked about the numerous blanks on R3's January TAR, V30

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(Licensed Practical Nurse/LPN) stated V30 did not know why they were blank. V30 stated R3 had "pretty good skin" in January. The facility was unable to confirm why these treatment dates and times were blank or provide documentation treatment was provided as ordered.

R3's progress note, dated 1/31/22 at 11:34 PM, reports R3 had complaints of shortness of breath and was transferred to the local emergency room for evaluation and treatment at this time. R3's local hospital emergency room notes, dated 2/01/22 at 2:19 AM, documents a chief complaint of shortness of breath with subsequent admission for treatment. R3 was discharged back to the facility on 2/14/22.

Included in R3's hospital record for this admission is a Wound Nurse Note, dated 2/07/22 at 12:27 PM, by V28 (Registered Nurse - RN) - "Consult completed for redness on coccyx. A picture was updated to pt (patient) chart. Pt has some blanchable redness, skin is C/D/I (clean, dry, intact). Triad applied to B/L (bilateral) and coccyx. A silicone bordered foam pad was applied to sacral region. B/L heels observed blanchable C/D/I. B/L pedal pulses 1+. B/L feet cold to touch. Pt stated she was cold. A warm blanket was placed over her after assessment was completed. Wound care will sign off at this time. Please consult again for any other wound care concerns."

R3's In-patient Discharge Summary, dated 2/14/22 at 12:05 PM, includes - "Physical Exam at Discharge: ...Skin: Stage II pressure ulcer bottom. R3's Primary Discharge Diagnoses include: Sepsis secondary to RLL (right lower lobe) pneumonia - improved; Acute on chronic hypoxia respiratory failure - improved." Pictures,

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S9999	Continued From page 7 dated 2/01/22 and 2/14/22, of coccyx/sacral area included in record. R3's hospital after visit summary, dated 2/14/22, gives instruction to continue the following to include - zinc oxide 20% ointment apply 1 application topically 2 times a day (apply to both buttocks for wound prevention). R3's facility admission evaluation note, dated 2/14/22 at 5:28 PM, documents no skin issues. R3's Braden Assessments - 2/14/22 - 13 moderate risks; 2/21/22 - 11 high risk; 2/28/22 - 15 low risk; 3/07/22 - 12 high risk; 3/15/22 - 16 low risk. On 03/31/22 at 1:49 PM, V2 (Director of Nursing - DON) stated the reason why R3's Braden scale scores from 2/14/22 to 3/15/22 were so up and down is because at different times V2 would be able to position herself better than others; some days R3 could get out of bed on R3's own, so the severity went back and forth depending on how R3 was the day of the assessment. V2 stated, "When (R3) discharged from the hospital and back to our facility, on 2/15/22, when I was in the room, the CNA (Certified Nursing Assistant, V24) pointed to (R3's) sacral area and asked what the dressing was. I observed a (hydrocolloid) dressing in place from the hospital from her discharge on 2/14/22. I knew it was not our dressing because we don't use that type." V2 stated V2 told V24 to "Get with R3's nurse to notify V30 (LPN/Wound Nurse) to come and assess what was under the (hydrocolloid) dressing." When asked why V30's weekly skin/wound evaluation documentation for R3 beginning 3/07/22 until R3's hospital admission on 3/25/22 were incomplete and unsigned, V2	S9999		

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stated V30 previously reported to V2 that V30 was approximately 4 weeks behind on V30's paperwork. V2 stated V2 did not realize R3's wound had declined to the point it had, until V2 went back into the role of DON on Monday, 3/21/22. V2 stated V2 doesn't know if the decline could have been prevented. V2 agreed on is there is a delay in processing the orders. V2 stated, "(V32, Wound Physician) gives a recommendation or order, (V30) does the treatment right then. I don't know why, according to the paperwork here, it's taking a day or two to put the order in for the rest of the nurses to follow."

R3's cumulative Order Review Report Summary documents an order for skin checks weekly and set schedule, I = Intact; N = New; W = Wound one time a day every Monday, Thursday for wound prevention, order date 2/14/22; start date 2/17/22; end date 3/26/22.

R3's February 2022 TAR documents two sets of skin check instructions. One (1) prior to R3 admitting to the hospital on 2/01/22, and a second (2) when R3 returned to the facility on 2/14/22 as follows:

1) Skin checks (Monday and Thursday) I = Intact; N = New; W = Wound, every day-shift Monday, Thursday, start date 12/10/20, discontinue date 2/11/22. This TAR documents on 2/03/22 by V7 (RN), the skin check is coded as a 3, indicating R3 is absent from home/hospitalized. A second skin check, dated 2/10/22 ,was documented as "I" for intact by V30, at which time R3 was still in the hospital.

2) Skin checks weekly and set schedule, I = Intact; N = New; W = Wound one time a day

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every Monday, Thursday for wound prevention, start date 2/17/22; end date 3/26/22. A skin check was performed on Thursday, 2/17/22 by V4 (LPN). V4 indicates a wound was present on this date by documenting "W." R3's next scheduled skin check, dated 2/21/22 is blank. The facility is unable to provide a reason it's blank or documentation that it was done.

On 4/05/22 at 10:55 AM, V4 stated the "W" she documented on R3's skin checks, dated 2/17/22, looked like a shear wound on the buttock, with redness around the middle. V4 did not remember which side, but stated V4 believed it was the left buttock. When wound pictures from 2/24/22 and 2/28/22 of the right and left buttock were shown to V4, V4 she stated V4 does not recall observing the right buttock wound, or any documentation in R3's record regarding treatment for R3's right buttock wound. V4 explained V30 normally did wound rounds and resident treatment through the week. V4 stated V4's "Understanding is that (V30) treats any wound with a covered dressing because that resident is on the weekly wound round list with the physician. (V30) treats those wounds daily and as ordered. The nurses scheduled on Saturday and Sunday provide wound care as ordered when (V30) is not scheduled to work."

R3's February 2022 TAR continues to document - zinc oxide 20% ointment apply to both buttocks topically every shift for wound prevention. Cleanse with wound cleanser and pat dry, apply z-guard every shift (6A-6P; 6P-6A), start date 3/27/21, discontinue date 2/07/22.

There is no order in R3's record or documentation on R3's February 2022 TAR for zinc oxide 20% ointment apply 1 application topically 2 times a

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S9999	Continued From page 10 day (apply to both buttocks for wound prevention) as documented on R3's hospital discharge summary instructions, dated 2/14/22. R3's February 2022 TAR skin checks, dated 2/24/22 and 2/28/22 are blank, however, V30 (LPN-Wound Nurse) performed a Skin and Wound Evaluation with R3 on these dates to include pictures. On 2/24/22, R3's skin and wound evaluation documents an abrasion to the left buttock as a new, in-house acquired wound measuring 0.6 cm (centimeters) in area x 1.2 cm length x 0.6 cm width with depth, undermining, and tunneling marked not applicable; 100% granulation with no evidence of infection, moderate serosanguineous exudate with no odor; edges attached; surrounding tissue normal in color; induration of less than 2cm around the wound; no swelling or edema; normal temperature; no pain reported; with goal of being healable. The attached picture of the left buttock, dated 2/24/22, documents a minute-old abrasion with visible multiple red areas that are open with skin peeling present. On 2/24/22, R3's skin and wound evaluation documents an undiagnosed wound to the right buttock as a new, in-house acquired wound measuring 1.3 cm x 1.8 cm x 0.9 cm with depth, undermining, and tunneling marked not applicable; 100% granulation with no evidence of infection, moderate serosanguineous exudate with no odor; edges attached; surrounding tissue normal in color; induration of less than 2cm around the wound; no swelling or edema; normal temperature; no pain reported; with goal of being healable. The attached picture of the right buttock, dated 2/24/22, documents an undiagnosed minutes old area that is visible in	S9999		

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the picture as a dark purple area with surrounding erythema.

On 4/07/22 at 1:49 PM, V30 looked at R3's picture V30 took from 2/24/22, and stated V30 would assess the left buttock wound as an abrasion, or maybe a stage I, since the skin is curled back and it's open. V30 stated, "Sometimes if I don't know what a wound is, I leave them blank and ask (V32) to classify them, and then go back and fill out the skin and wound evaluation that time." V30 looked at the skin and wound evaluation of R3's right buttock, dated 2/24/22, and stated V30 would describe it as an unstageable DTI (deep tissue injury). V30 confirmed there was no order for treatment to either R3's left or right buttock for February, only skin checks on R3's February TAR, and V32 would not have known about R3's wound to this point.

R3's cumulative Order Review Report documents an order, dated 3/02/22, for Mupirocin ointment 2% apply to left buttock topically as needed for wound AND apply to left buttock topically every day-shift for wound, cleanse with wound cleanser, apply mupirocin, and dry dressing. Start date, 3/02/22, end date 3/08/22. This order does not include the right buttock.

On 4/07/22 at 1:49 PM, V30 continues to state R3's right buttock wound may not have been brought forward to the physician's order sheet or TAR for treatment, but did state per V30's hand-written wound notes, treatment was done to R3's bilateral buttocks on 3/01/22.

V30's hand-written wound note - 3/01/22: left buttock 0.9cm x 0.7cm with moderate 100% granulation; right buttock 1.2cm x 1.4cm with

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moderate 100% granulation - treated with Mupirocin, DD (dry dressing).

R3's progress skin/wound note, dated 3/01/22 at 7:08 AM, by V32 (Wound Physician) documents R3 has wounds to bilateral buttocks described as an abrasion with an onset within a week. V32 describes the wound as open with a dry scab. Location: Right buttock: 1.2 cm x 1.4 cm x 0.1 cm with moderate drainage and 100% granulation. Left buttock: 0.9 cm x 0.7 cm x 0.1 cm with moderate drainage and 100% granulation. Diagnosis: Right and left buttocks wound - abrasion. Plan: Dressing. Dressings: Mupirocin with dry dressings change daily and PRN (as needed).

R3's progress note, dated 3/01/22 at 2:18 PM by V30, documents V30 spoke to R3 regarding R3's wound and R3 had no questions or concerns.

R3's March 2022 TAR documents the following - 1) Skin checks weekly and set schedule, I = Intact; N = New; W = Wound, one time a day every Mon, Thurs for wound prevention, start date 12/17/22 end date 3/26/22; 2) Mupirocin ointment 2% (percent) apply to left buttock topically as needed for wound - start date 3/02/22, end date 3/08/22. 3) Santyl ointment 250 unit/gram (collagenase) apply to sacrum topically every dayshift for wound, cleanse with wound cleanser, pat dry, apply Santyl, calcium alginate, and dry dressing - start date 3/09/22, end date 3/26/22. 4) Santyl ointment 250 unit/gram (collagenase) apply to right lower back topically every dayshift for unstageable wound, cleanse with wound cleanser, pat dry, apply Santyl with calcium alginate, and dry dressing, start date 3/26/22, end date 3/26/22.

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S9999	Continued From page 13 R3's March TAR has one skin checks area documented as completed on 3/03/22, and coded with a "3", indicating a wound is present; Skin and wound evaluations forms, dated 3/07, 3/14, and 3/21, were not completed and were unsigned by V30. R3's skin checks for 3/10, 3/17, and 3/24 are blank. The facility did not provide documentation skin checks were completed on these days. Also pertinent on this TAR, treatment with Mupirocin ointment 2% apply to left buttock every dayshift (6A-6P) for wound, cleanse with wound cleanser, apply mupirocin, and dry dressing. Start date 3/02/22, end date 3/08/22. The date 3/04/22 is blank. The date 3/08/22, signed by V30, is coded as "9" for see progress notes. The facility did not provide a corresponding progress note regarding this skin check. This TAR does not include the right buttock, and the facility was unable to provide documentation of treatment to the right buttock other than on V30's wound round days when V30 provided V30's hand-written notes on 3/01/22 and 3/08/22. R3's Skin and Wound Evaluation, dated 3/07/22 at 10:20 AM - Abrasion to sacrum new in house acquired at 10.2cm x 3.0cm x 5.3cm, depth not applicable. The remainder of the evaluation is blank and has not been signed off by V30. Wound evaluation picture, dated 3/07/22, documents sacral abrasion 11-day old in house acquired as 10.18cm x 2.99cm x 5.3cm. V30's hand-written note - 3/08/22: left buttock no measurements, right buttocks no measurements, sacrum 3.0cm x 5.3cm with moderate 100% granulation - treated with Santyl and CA (calcium alginate), DD, marked as "decline." R3's progress note, dated 3/08/22 at 11:21 AM by V30, documents, "Spoke with resident in regard to	S9999		

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wound. Expressed the importance for resident to rotate side to side to keep pressure off wound. Resident verbalizes understanding. Resident has no questions or complaints at this time."

R3's skin/wound note, dated 3/08/22 at 6:49 AM by V32, documents buttock wounds within a week as an open abrasion with dry scab. Wound to buttock has migrated to fuse at the sacrum. Pt is bed bound. Sacrum 3.0cm x 5.3cm x 0.1cm moderate drainage 100% slough with 0% granulation. Diagnosis: Sacrum wound - abrasion. Plan: dressing switch to Santyl with dry dressing change daily and PRN. There is marked decline observed in the corresponding picture, dated 3/07/22, with redness evident from the right hip across the buttock, sacral area, and visible on the lower back region. This surveyor observed R3's wound picture. R3's buttocks/sacral area appear inflamed and swollen even in the picture, with a large purple/black area across the right buttock to the sacral region.

R3's cumulative Order Review Report documents an order for - Santyl ointment 250 unit/gram (collagenase) apply to sacrum topically every day-shift for wound, cleanse with wound cleanser, pat dry, apply Santyl, calcium alginate, and dry dressing - start date 3/09/22, end date 3/26/22.

R3's March TAR document is blank on 3/09/22, 3/18, and 3/24 when R3 should have received Santyl ointment 250 unit/gram (collagenase) apply to sacrum topically every day-shift for wound, cleanse with wound cleanser, pat dry, apply Santyl, calcium alginate, and dry dressing - start date 3/09/22, end date 3/26/22. The facility did not provide an explanation or documentation why the treatment was not done on these dates

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R3's Skin and Wound Evaluation, dated 3/14/22 at 10:26 AM - Abrasion to sacrum new in house acquired at 9.1cm x 2.1cm x 6.1cm, depth not applicable. The remainder of the evaluation is incomplete. Wound evaluation picture, dated 3/14/22, documents sacral abrasion 18 days old in house acquired at 9.14cm x 2.09cm x 6.07cm. This picture has a marked increase in size difference appearing larger in the picture taken on 3/07/22.

V30's hand-written note - 3/15/22: sacrum 2.1cm x 6.1cm with moderate 80% S (slough), 20% G (granulation) - treated with Santyl, CA (calcium alginate), DD (dry dressing). Written on this sheet is - "silicone", "1-hour turn schedule", "high protein diet."

R3's skin/wound note, dated 3/15/22 at 6:44 AM by V32, documents - patient has wound: buttocks wounds. Onset within a week. Type of wound: abrasion, open with dry scab. Wound to buttock has migrated to fuse at the sacrum. Pt is bed bound ...location: sacrum 2.1cm x 6.1cm x 0.1cm abrasion with moderate 80% slough and 20% granulation. Diagnosis: sacrum wound - abrasion, slightly worsen. Plan: dressing switch to Santyl with dry dressings change daily with one-hour turn schedule, change daily and as needed.

R3's progress note, dated 3/15/22 at 11:37 AM by V30, documents - "Spoke with resident in regards to current wound. Reminded resident to make sure she is turning side to side to keep off her sacrum. Will place on a 1-hour turn schedule. Resident has no questions or concerns at this time."

R3's skin and wound evaluation, dated 3/21/22 at

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S9999	Continued From page 16 12:49 PM by V30 - Abrasion to sacrum new in house acquired at 19.5cm x 5.4cm x 4.1cm, depth not applicable. The remainder of the evaluation is incomplete. Wound evaluation picture, dated 3/21/22 documents 25 day old in house acquired sacral abrasion at 19.46cm x 5.41cm x 4.14 cm. R3's wound in this picture has significantly declined when compared to the assessment picture from 3/14/22, with obvious depth and a dark, necrotic looking wound to the right hip as seen in the corner of the sacral photograph. R3's skin and wound evaluation, dated 3/21/22 at 12:49 PM - Pressure to right lower back (slough and/or eschar), new in house acquired and unstageable (obscured full-thickness skin and tissue loss) at 4.6cm x 2.3cm x 2.7cm, depth not applicable. The remainder of this evaluation is incomplete. Wound evaluation picture dated 03/21/22 documents new unstageable pressure (slough and/or eschar) minute old in house acquired right lower back wound at 4.63cm x 2.27cm x 2.69cm. R3's skin/wound note, dated 3/22/22 at 6:45 AM by V32, documents - patient has wound: buttocks wounds with a new wound of lower back. Onset: months. Type of wound: abrasion. Status: open, wound was to buttocks but migrated to fuse at the sacrum. Pt is bedbound. Location: sacrum 5.4cm x 4.1cm x 0.1cm abrasion with moderate drainage and 80% slough, 20% granulation. Wound: right lower back pressure wound - unstageable with 100% slough. 2.3cm x 2.7cm x 0.1cm. diagnosis: sacrum wound - abrasion, worsen. Right lower back pressure wound: unstageable. Plan: dressing, added abd (army battle dressing) pad with Santyl with dry dressings change daily and	S9999		

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prn with 1-hour turn schedule and prostat juice.

R3's hand-written wound note by V30, dated 3/22/22 documents - sacrum abrasion/worsen 5.4cm x 4.1cm with 80% S, 20% G, moderate; right lower back new (unstageable change) 2.3cm x 2.7cm 100% S moderate - both areas treated with Santyl, CA, DD. Written on sheet - "Add high protein diet", "Prostat with juice", "able to make own decisions?"

On 4/07/22 at 1:49 PM, V30 explained V32 documents V32's would assessments in the electronic record along with the measurements, description, and everything from week to week, including his diagnosis and treatment orders. V30 stated V30 will get V30's measurements and pictures on Mondays, then will go back on Tuesday or Wednesday after rounding with V32, look at V32's notes, and fill in the assessment documentation in the electronic record. When asked about R3's wound note written by V32, dated 3/01/22, referencing both the left and right buttock wound with orders to treat, V30 stated V30 thought the orders for R3's right buttock got put on the POS and TAR. V30 did not remember what or who prompted V30 to do R3's skin and wound evaluation and take pictures on 2/24/22 or 2/28/22, but V32 would not have been aware of any wounds until03/01/22 when V32 made V32's first note. V30 stated V30 was told the pictures had to be within 7 days of seeing the wound doctor, so V30 may have input the measurement and descriptions from 3/01/22 into the documents for 2/24/22 and 2/28/22. V30 stated R3 was ordered to be on a 1-hour turn schedule on 3/15/22, as documented in V32's wound note. V30 stated V30 "swears" V30 put the order on the POS and CNA tasks, but this did not get documented in the tasks at all, or on the POS or

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care plan until 3/21/22. The 1-hour turn schedule was never implemented, due to not being put in the tasks where the CNAs could follow the recommendation. V30 remembered doing this, but must not have saved it in the computer. V30 stated V30 remembers telling the CNAs R3 was on a 1-hour turn schedule, but it's not documented, and was not done. V30 confirmed there was no documentation of treatment for R3's buttocks until 3/02/22, and it was only for the left buttock. The right buttock did not get brought forward from V32's note on 3/01/22. V30 confirmed V30 provides resident wound treatment on Monday - Friday for all covered wounds V32 has on V32's weekly rounds. V30 stated V32 did give treatment orders for R3 on 3/01/22 for Mupirocin to bilateral buttocks with dry dressing. V30 did not include the right buttock on the orders or TAR. That is V30's fault. V30 may not have put it in the computer, but treatment was being done to R3's bilateral buttocks, and provided hand-written wound sheets indicating it was done, just not documented on the POS or TAR. V30 stated V30 would not have been there on the weekends to provide treatment, so the nurses would not have known to treat R3's right buttock, because it was not in the computer. V30 stated V30 only had documentation wound care to R3's right buttock was done by V30 during the week, as described in V30's hand-written notes on 3/01, 3/08, 3/15, and 3/22. V30 could not confirm full treatment was completed on any other days to the right buttock. V30's provided V30's wound treatment notes for 3/01, 3/08, 3/15, and 3/22, but was unable to confirm R3's treatment to the right buttock was completed on any other days during the week or on the weekends. When asked if V30 observed R3's wounds declining, V30 stated R3's wound did smell slightly, and gradually got worse with the

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decaying of the skin. V30 had no idea when V30 first noticed the odor, but because of R3's decline, V30 "honestly thought it was Kennedy ulcer because she just laid there." V30 stated V32 never mentioned a Kennedy ulcer to V30. V30 continued to state on 3/24/22, R3's sacral wound "stunk to high heaven" with a lot of drainage. That's when V30 got an order from V31 (Nurse Practitioner - NP), who works in the facility, to do a wound culture, and V31 ordered labs on 0/25/22. V30 again confirmed R3 received no treatment to either buttock between 2/15/22 and 3/01/22. When asked about 3/09, 3/18, and 3/24 being blank for treatment on the TAR, V30 stated V30 could have forgotten to document on the TAR.

R3's cumulative Order Review Report documents - Santyl ointment 250 unit/gram (collagenase) apply to right lower back topically as needed for unstageable AND apply to right lower back topically every day shift for unstageable wound, cleanse with wound cleanser, pat dry, apply Santyl with calcium alginate, and dry dressing, order/start date 3/25/22, end date 3/26/22; 1-hour turn schedule order date 3/21/22 with no start date; obtain wound culture to sacrum for possible infection, order date 3/24/22; Remeron table 15 mg (milligram) give 1 tablet by mouth at bedtime for appetite, order/start date 3/22/22, end date 3/26/22; Pro-Stat liquid give 30 ml (milliliter) by mouth three times a day for wound healing mix with a juice, order/start date 3/25/22, end date 3/26/22; lab: complete blood count with differential and CMP (comprehensive metabolic panel) one time only for lab monitoring for 1 day, order/start dated 3/25/22, end date 3/26/22.

R3's March 2022 MAR (Medication Administration Record) documents she received two doses of

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Remeron on 3/23/22 and 3/24/22, and one dose of Pro-Stat on 3/25/22.

R3's progress notes are as follows - On 3/24/22 at 11:24 AM, V30 documents a wound culture was obtained to the sacrum due to decline in wound and possible infection. On 3/25/22 at 11:14 AM, V30 writes, "Spoke with resident in regards to current wounds. Resident has no questions or concerns at this time ..." On 3/25/22 at 3:52 PM - new order for labs received from V31 (Nurse Practitioner - NP). Drawn and picked up by lab. On 3/25/22 at 9:40 PM - facility received a call from lab regarding abnormal results for R3. Verbal orders to send to hospital due to hemoglobin at 6.3. Resident transported to local hospital emergency room via ambulance at 9:11 PM. 3/25/22 at 10:19 PM - facility received call from local hospital emergency room to report R3 was receiving blood transfusion at the moment. 3/25/22 at 10:40 PM - hospital called facility requesting POA (power of attorney) paperwork be faxed to them.

R3's hospital Transfer Form completed by V10 (LPN) documents reason for transfer as abnormal hemoglobin or hematocrit (low). Skin wound care for pressure ulcers/injuries (stage, location) is blank. Other wounds or bruises present is marked no.

R3's lab work taken on 3/25/22 was marked as received by the facility on 3/28/22 - Wound culture final result: Heavy growth proteus mirabilis with additional heavy growth mixed skin flora. Gram stain result: Rare polymorphonuclear leukocytes; many gram-positive cocci in pairs and clusters; many gram positive bacilli; few gram-negative bacilli. R3 is currently admitted to the local hospital.

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S9999	Continued From page 21 V30's hand-written wound note form, dated 3/29/22, documents R3 is in the hospital. R3's hospital notes are as follows - ED (emergency department) HPI (history of present illness), dated 3/25/22 at 10:56 AM by V25 (hospital physician)- "Abnormal lab (hemoglobin 6.0 per nursing home) ...per emergency medical services 6.0 hemoglobin, patient on 4 liters nasal cannula per baseline ...multiple bedsores. Patient pleasantly confused upon arrival, unable to tell year. Pale but responding to staff. Paperwork from nursing home states hemoglobin 6.3 with history of anemia. Physical exam - ...Skin comments: Large bandaged sacral decubitus with approximately 5cm of surrounding erythema, warm to touch...She remained overall stable through her emergency department course. She had tachycardia. On head-to-toe examination the sacral decubitus ulcer with evidence of surrounding cellulitis was appreciated, and I believe that this is the mostly likely source. I absolutely believe that she requires hospitalization for continued evaluation and treatment. I discussed all currently available information directly with V22 (hospital physician) who agrees to bring this patient onto their service and agrees to transfer care." Clinical impression: Sepsis with acute organ dysfunction due to unspecified organism; cellulitis of buttock; pressure injury of skin of sacral region, unspecified injury stage. R3's patient image of the left buttock, dated 3/25/22 at 11:21 PM, captures a very large, black/necrotic, infected area to the entire back side with the right lower back/hip area visible in this scan, also observed as black and necrotic. 3/26/22 HP (history & physical) by V22 (hospital	S9999		

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S9999	Continued From page 22 physician) - Active hospital problems and plan: ...Severe sepsis likely from necrotic sacral ulcer ...please consult surgeon in the morning ...toxic metabolic encephalopathy, improving, likely from infection/dehydration ...This hospital documentation has included a comparison picture from 2/14/22 to this admission with marked deterioration. Operative Note - Date of procedure 3/25/22 and 3/26/22 by V21 (Surgeon) as follows in part - pre-operative diagnosis: Sacral decubitus ulcer; necrotizing soft tissue infection; sepsis. Post-operative diagnosis: Same. Procedure Performed: Wide debridement of necrotizing soft tissue infection of sacrum and bilateral gluteal regions. Findings: Skin excision 21.5 x 14 cm with sharp debridement of subcutaneous fat, fascia, and gluteus muscle. Extensive necrosis of the deep fat, fascia, and muscle of the sacrococcygeal and bilateral gluteal regions. Wound tracked 6.5 cm deep in the right gluteal region. Specimen: Sacrococcygeal skin, fat, and fascia tissue for culture and pathology. R3's patient image of the initial debridement phase captures R3's back side bilateral buttocks, reaching up and onto the lower back region, then down the right leg to mid-thigh being void of skin, tissue, and muscle down to the bone visible in some areas. Final debridement dated 3/26/22 is obviously larger in size and down to the bone. Wound nursing note by V11 (hospital RN) documents 'wound vac application was performed noting that patient wound has become more necrotic since debridement. Will plan to change wound vac on 4/01/22.' On 4/05/22 at 4:10 PM, V11 (Hospital RN/Wound Care) stated R3's whole situation was 'horrible.' V11, V14 (POA - Power of Attorney), and V21 agreed moving forward, comfort care would be in order. V11 stated they usually change the wound	S9999		

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S9999	Continued From page 23 vac every other day, but won't continue to do this. V11 reported R3 had been taken off wound care's list as of 4/04/22, and placed on comfort care at this time. V11 stated as of 4/05/22 at 10:25 AM, per V17's (Physician) note in R3's hospital record documented they are holding on the hospice referral, but noted significant changes in respirations. V11 stated Case management left a detailed message for V14, and a hospice company reference ...V11 continued to state, "it looks like the wound vac is still in place and they probably don't want it removed due to pain ..." On 4/07/22 at 8:00 AM, V6 (RN) stated V6 provided wound care with the previous wound care physician prior to V30 taking over last summer ... "In the past, when I was rounding with the wound physician, if I didn't agree with a treatment, I would ask the physician for their rationale they had in place and then ask why we were not doing "A", "B", "C", and "D". I would follow the physician's orders, then put it in the computer and implement that order ... If a wound worsens, you would stage up and document as such. If the wound would began to heal, it would be a healing stage II or whatever, and your documentation would reflect that in your assessment. I would have never started the wound to the left buttock as an abrasion. That would have been the point where I would have consulted with the wound physician and asked for his rationale and where he believed the abrasion came from (what caused it). If he said this is my rationale and I'm not changing it, then I would tell him he needed to make a clear progress note, and my note would say what my assessment deemed, what he said, and I would ask him to be present when I call the family so that he can assist in explaining and provide his rationale ... Any wound present you would use nursing	S9999		

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judgement 101, you would implement a consistent turn schedule. Recommend to Dietitian. (R3) did not have Pro-Stat and multi-vitamins until 3/25/22. Based on the changes over the 6-week course from 2/14/22 to 3/25/22, you would get wound cultures, labs, which were not ordered until 3/24/22 and 3/25/22."

On 4/07/22 at 11:27 AM, V9 (RN) stated V9 observes inconsistencies in treatment orders versus the wound orders given, and time it takes to implement and the follow-up for wound care is "not good." V9 stated V30 does wound care Monday through Friday for residents on the physician's wound schedule, and nursing takes over on the weekend to provide treatment when V30 does not work.

On 4/07/22 at 11:52 AM, V24 (CNA) stated when R3 came back from the hospital on 2/14/22, R3 was wearing heel protectors and had a bandage on R3's coccyx area. V24 stated V2 came in the room and assisted V24. V24 stated, "We brought (V30) in because (R3's) butt was red." V24 stated V24 does not recall seeing R3's buttocks after that because there was always a dressing on it, but stated, "If it was soiled, we would take the bandage off and notify the nurse." V24 does not recall observing an open area, just redness, and stated suddenly there was a wound, but does not remember dates. V24 confirmed the last time V24 saw R3's buttocks wound was on 3/24/22, the day before R3 went to the hospital. R3 had no output that day, and the wound was, "not nice, it was ugly." V24 stated R3 was not eating or drinking, and was declining.

On 4/07/22 at 12:00 PM, V23 (CNA) stated V23 worked on R3's hall prior to R3 admitting to the

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hospital on 3/25/22. V23 stated on Sunday, 3/20/22, when V23 turned R3 to R3's left side, V23 noticed an open wound, and notified the nurse because V23 had also noticed an odor. V23 stated the nurse came and cleaned R3's wound. V23 stated V23 did observe exposed tissue at this time. V23 stated on 3/24/22, V23 again observed R3's open wound, and it had a bad odor. V30 came and took care of this on 3/24/22. When asked, V23 stated R3 was on a 2-hour turn schedule. "We would start with her right side, then left side, then back." V23 stated R3 was not able to turn by herself, but "she could wiggle to situate once we had her in place." V23 stated V23 does not remember R3 having wounds in January 2022 when V23 started working in the facility. V23 stated R3 required a mechanical lift for transfers, and this was painful for R3. "When she would agree to a shower, we would put her on the shower bed via (mechanical) lift and take her down to get a shower.

On 4/07/22 at 1:42 PM, V27 (CNA) stated V27 was aware R3 had a wound because the CNA who cleaned R3 would comment that we might need to change R3's bandage and would notify the nurse. "I just started here three months ago, so the other CNAs know more about her than I do. I know she would not feel good on her shower days, but she would get a bed bath. Sometimes, she would say no, but she would agree to be washed off in the bed. I know her anxiety played a part in her refusal. We tried to make it as comfortable as we could." V27 stated V27 could not tell the surveyor what R3's wound looked like, because V27 would be providing support by holding R3 and standing in the front side of R3.

On 4/08/22 at 8:56 AM, V7 (RN) stated V7 does

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not remember anyone coming to V7 regarding R3's wound on 2/15/22. "I remember redness and that we were putting zinc oxide on the sacral redness. I do not remember when it started. I know (V30) is the wound nurse, so we really did not see the area much because she was doing daily treatment and once a week with (V32). I think he comes in on Tuesdays." V7 stated R3's sacral area was pretty red because R3 was non-complaint with eating, drinking, turning ,and just non-compliant with getting up and being mobile. R3 was able at times, but even with education, R3 would refuse.

On 4/08/22 at 9:05 AM, V28 (RN) stated V28 worked weekends on Saturday, 2/19/22, Saturday, 2/26/22, and Sunday, 2/27/22 and does not remember observing any orders regarding R3's skin these dates.

R3's bath look back report, dated 2/06/22 through 3/24/22 documents the following care given - 2/17/22 NA (not applicable); 2/21/22 BB (bed bath); 2/24/22 PB, 4, 2 (partial bath, total dependence, one person physical assist); 2/28/22 RR (resident refused); 3/01/22 SH, 4, 2 (shower, total dependence, one person physical assist); 3/03/22 RR; 3/07/22 NA; 3/10/22 RR; 3/14/22 RR; 3/17/22 PB, 4, 2; 3/21/22 SH, 4, 2; 3/24/22 BB, 4, 3 (bed bath, total dependence with two plus person physical assist).

On 4/08/22 at 10:06 AM, V3 (LPN - MDS/Minimum Data Set) stated the "7" on R3's MDS for functional status self-performance during transfer and locomotion on/off unit, dated 2/22/22, means "The activity only occurred once or twice with the support required that is documented as being two plus person physical assist. It does not mean independent of any help or on her own."

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S9999	Continued From page 27 On 4/08/22 at 11:00 AM, V13 (CNA) stated V13 has no recollection of anything V13 would have reported to nursing regarding R3's sacral area from 2/14/22 to 3/25/22. On 4/08/22 at 2:08 PM, V20 (LPN) stated sometimes V20 would get confused when, on rare occasions, V20 would fill in for wound care on V20's shift, when V30 could not get to them all. V20 stated some of the orders did not seem to be updated in accordance with the wound flow, or corresponding condition of the wound V20 was observing at the time. V20 stated V20 does not have a specific example; it was just something she remembered questioning at the time. On 4/05/22 at 11:18 AM, V32 (PCP - Primary Care Physician/Wound Specialist) stated when V32 first began treating R3 (3/01/22), her wound to the sacral region started as what looked like a shear/abrasion ... "I know she's had pressures in the past that have been healed. She was anemic, COPD, albumin was low. I try to look at their kidneys, blood level, protein levels, 02 was subjectable with COPD for getting enough 02 (oxygen) to the tissue which plays a part in wounds, as well. I saw some tissue growth and what almost looked like a DTI with underlying redness to the wound on the second round (3/08/22) and I didn't switch the description to pressure wound quite yet. The third time (3/15/22), I talked with R3 she was not with it. I asked her if she gets out of bed. I asked the staff and they said no. She has history of anorexia and will not get out of bed. I asked her if she got out of bed and ate well. She said yes, but I doubted she was doing either. She is with it at times, but after valium she is out of it and just wants to lay in bed. She did not complain of any	S9999		

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S9999	Continued From page 28 pain to her back side. At this time, I considered the wounds more of a pressure wound and switched her to turn every 1 hour around the 2nd or third visit. I don't know if the staff were following orders 100%, and sometimes there would not be a dressing in place when I would begin my wound care. At the last visit, when I saw her on 3/22/22, I was thinking it was a Kennedy wound to the sacral area, very bony, poor nutrition, anemia, and not getting out of bed. If I would see her again, I would ask PCP for hospice care. The hospital went on with surgical intervention for debridement. It was a fast decline. For avoidable or unavoidable it's hard to say. I will say that if every order and treatment were in place and being done as prescribed, it would possibly be avoidable. It is a hard thing to say. All unavoidable wounds are usually stated after the fact. There is no true standard. I'm not sure what else I could have done differently, maybe consider debridement on my last treatment. I did not have any indication per her wound observation or vitals on 3/22/22 that she was septic, and the wound did not have an odor. The large slough wounds are difficult to say regarding infection because there will be SOME type of infection present. There was nothing clinically on physical exam that would indicate she was in the process of becoming septic or that a wound culture was warranted." V32 continued to state "Typically, the hospital would not debride again after the first surgical debridement. If pressure was the major cause, the wound vac placed after debridement would usually lend an improvement. Typically, if you don't see improvement, it is usually due to co-morbidities that would cause the wound and not just pressure related. Minor slough may be debrided in the future. If the wound is healable, the wound vac could accomplish healing with the pressure injury	S9999		

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S9999	Continued From page 29 part of the issue. If you are still getting slough, the wound is still dying, and pressure would not be the main issue." On 4/06/22 at 9:56 AM, V21 (hospital surgeon) stated R3 had a wound to the sacral region when R3 discharged from the hospital on 2/14/22 and went back to the facility. This wound progressed to a stage 4 sacral ulcer that was not healing or improving since 2/14/22, up to R3's most recent admission on 3/25/22. "She's been very anxious and not wanting to participate in her care here. That's why the decision was made to place her on comfort care in the hospital at this time." V21 stated, "I surgically debrided her wounds on 3/25 and 3/26, and over the past few days I've observed the wound and there is more necrotic development. Part of it could be her malnutrition, and she is still putting pressure on the wound. She does not want to be moved or the nurses don't want to move her because she is anxious. The rapid decline over the past 6 weeks was disturbing to me" and stated she had not seen it this bad before. "It draws the concern as to whether there was neglect by the facility. Sacral wounds are always avoidable. People still get them unfortunately, but again it really concerned me when I saw how bad it was." V21 continued to state, "Just the fact they waited long enough with the severity of the wound and to the point she became septic and so sick upon arrival to the emergency department was concerning." V21 stated R3 had to be admitted to the ICU (intensive care unit) and started on antibiotics. V21 stated, "I've seen this before coming in sick with a sacral wound, but the magnitude of the wound, stage IV, and our documentation of what the wound looked like 6 weeks prior, it's concerning to me. I just hope this doesn't happen to someone else. Even if someone is	S9999		

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malnourished and does have diagnoses like she did, such as anorexia, COPD, poor intake, that does not negate the fact they waited so long to seek further treatment." When asked if she had discussed the possibility R3's wound could be classified as a Kennedy ulcer, as discussed by the hospital wound nurse (V11), V21 stated V21 remembered V11 mentioning that, but as a physician, V21 did not learn about Kennedy ulcers in medical school, and did not believe R3's wound was a Kennedy ulcer due to the 6-week progression and wound declination from last hospital discharge, dated 2/14/22.

R3's Certificate of Death Worksheet includes the following - Date of Death: 4/06/22. Time of Death: 6:58 PM. Cause of Death: a) Sepsis with multi-organ failure.

2. R1 admitted to the facility on 3/23/22, with the following diagnoses, in part, as documented on her Admission Record Diagnosis Information Sheet - Anemia, type II diabetes mellitus, moderate protein-calorie malnutrition, heart failure, chronic kidney disease, and presence of cardiac pacemaker. R1 is her own representative.

R1's admission MDS (Minimum Data Set), dated 3/30/22, documents R1 is cognitively intact. R1's clinical admission evaluation note, dated 3/23/22 at 6:35 PM, does not document any skin issues, blisters, or pressure areas to R1's body on admission.

R1's Braden Assessment, dated 3/23/22, documents a score of 18, indicating R1 is low risk for developing pressure sores. (Severe Risk: Total score less than 9; High Risk: Total score 10-12; Moderate Risk: Total score 13-14; Mild

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S9999	Continued From page 31 Risk: Total score 15-18). R1's March 2022 Order Summary Report documents the following in part - 1) Order date 3/24/22 - Start date 3/28/22: skin checks Monday and Thursday, 1 time week, every shift 6:00 AM - 2:00 PM I = Intact, N = New, W = Wound in the morning every Monday, Thursday for skin integrity. R1's March 2022 TAR (Treatment Administration Record) also documents the following in part - Skin checks Monday Thursday 1-time weeks, every shift 6:00 AM - 2:00 PM, I = Intact, N = New, W = Wound in the morning every Monday, Thursday for skin integrity, start date 3/28/22. This TAR indicates a skin check was performed as ordered on Monday, 3/28/22 and documented as "I" for intact skin; and 3/31/22 documented as "W" for wound. R1's Skin and Wound Evaluation, dated 3/28/22 by V30 (Licensed Practical Nurse - LPN/Wound Nurse), documents R1 has a new in-house acquired blister to the left heel measuring 4.8cm (centimeter) x 2.1cm x 2.8cm. The remainder of the skin and wound evaluation is blank and unsigned. R1's Wound Evaluation, with color photo dated 3/28/22 at 2:52 PM by V30, captures an image of a left lateral (outside) heel wound measured at 4.75cm x 2.06cm x 2.84cm described as, "new - minutes old, in-house acquired blister to the left heel. This Wound Evaluation is not signed or dated. R1's March 2022 Order Summary Report includes - 2) Order/Start date 3/29/22: apply dry dressing to left heel blister as needed for stage II	S9999		

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blister; 3) Order date 3/29/22 - Start date 3/30/22: apply dry dressing to left heel blister every day-shift for stage II blister; 4) Order/Start date 3/31/22: Cleanse left heel wound with wound cleanser and pat dry. Apply calcium alginate, super absorbent, wrap with kerlix, and secure with tape daily; 5) Order date 3/31/22 - Start date 4/01/22: cleanse right heel wound with wound cleanser and pat dry. Apply skin prep, allow to dry, wrap with kerlix, and secure with tape daily.

R1's March 2022 TAR includes - Apply dry dressing to left heel blister every day-shift for stage II blister, start date 3/30/22, discontinue date 3/31/22. This TAR indicates treatment was performed on Wednesday 3/30/22.

On 3/31/22 at 2:05 PM, R1's wound treatment was observed with V9 (Registered Nurse - RN) and V6 (RN). V9 removed the dressing on R1's left foot. Present, was a large white closed wound to the left lateral side of heel as depicted in the photograph taken by V30 on 3/28/22. Also observed was a large white round wound to the bottom of R1's left heel. The heel/plantar area of R1's left foot that encompassed these two wounds appeared macerated. There is no documentation in R1's record regarding the wound to the bottom of R1's left heel. Also observed, was a bandage on R1's right heel that was neither dated nor signed. When asked, V6 or V9 could not provide any information regarding a wound to the right heel, or treatment orders for this area. At this time, R1 stated that a "blonde-haired girl" came in on Tuesday, 3/29/22 and put in on R1's right foot. R1 did not know her name. V9 removed the bandage to the right heel, and a pressure area was observed. This surveyor called V6 back into the room to assess R1's left foot and right heel. V6 stated V6

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believed the dry dressings might be causing the maceration. V6 identified the wound to right heel as a stage II pressure ulcer measuring 3cm x 1.7cm x 0 depth. At this time, V6 called V31 (Nurse Practitioner - NP) and obtained a new order for the left foot - cleanse left heel wound with wound cleanser and pat dry. Apply calcium alginate, super absorbent dressing, wrap with Kerlix, secure with tape daily and as needed for stage II blister. V31 also gave orders for R1's right foot treatment - skin prep, dry, wrap with Kerlix, secure with tape daily and as needed. At this time, R1's March 2022 TAR skin check was completed and documented as "W" for wound.

R1's progress note, dated 3/31/22 at 2:51 PM by V6, includes - Right heel stage 2 pressure ulcer measures 3x1.7xNM. No redness notes. BLE (bilateral lower extremity) pitting edema noted. NOR (new order received) per (V31) to apply skin prep, allow to dry and wrap with kerlix daily. Left heel, NOR related to deterioration to apply calcium alginate, super absorbent pad, wrap with kerlix and secure with tape daily and as needed.

On 4/05/22 at 10:00 AM, when asked about R1's wound to the bottom left heel, V30 replied, V30 had not seen that one, only the spot to the left lateral side of the foot, which they were treating. V30 also stated V30 was unaware of the wound to the bottom of R1's right heel, and does not know who placed the bandage on it, but it was not V30. V30 confirmed R1's left foot was assessed on 3/29/22, but V30 did not remove the sock on R1's right foot, so V30 was unaware of the wound or presence of a bandage. This area would not have been picked up on wound rounds.

On 4/05/22 at 11:18 AM, V32 stated R1's bilateral heels were not being treated, only the left lateral

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heel as per the orders.

3. R4 admitted to this facility on 12/09/21 following an out of state hospital admission, dated 12/01/21 to 12/09/21. R4's hospital record discharge summary, dated 12/09/21 at 1:46 PM, includes the following - Admitting diagnosis: Osteomyelitis of the right foot. Physical Exam documents skin is free of lesions or rashes. Right 5th toe ulcer. Assessment/Plan includes: Right foot ulcers with osteomyelitis, history of clostridium difficile, acute urinary retention (patient failed a voiding trial hence foley catheter replaced), type II diabetes (DMII), chronic kidney disease stage 3 (CKDIII), benign prostatic hyperplasia (BPH), recent recovery from Covid with respiratory failure. Discharge diagnosis: Osteomyelitis. Assessment/Plan: Right foot ulcers with osteomyelitis. Disposition: SNF (skilled nursing facility). There is no documentation in this hospital record indicating R4 experienced skin issues involving bed sores. Hospital Course summary includes acute urinary retention with neurology following.

R4's facility diagnosis sheet, dated 12/09/21, includes primary admitting diagnoses as - personal history of Covid-19, chronic respiratory failure with hypoxia, DM II, hypertension, BPH with lower urinary tract (UTI) symptoms, CKD III, obstructive and reflux uropathy, osteomyelitis, acquired absence of right toes. R4 received the following additional diagnoses in part - E-coli due to c-diff (2/08/22), UTI (2/28/22), extended spectrum beta lactamase (ESBL), bacterial infection, lobar pneumonia (3/10/22), chronic diastolic heart failure (3/17/22).

R4's Admission Braden Assessment, dated 12/09/21, documents R4 is at low risk for

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S9999	Continued From page 35 developing pressure sores with a score of 20. R4's most recent Q (quarterly) MDS, dated 3/16/22, documents R4 is cognitively intact with a BIMS of 15, and acts as R4's own representative. R4's facility cumulative Order Summary Report includes - Bacitracin-Polymyxin ointment apply to affected areas topically every shift for skin integrity, start date 12/10/21; Miconazole Nitrate Powder 2% apply to affected areas topically every shift for excoriation, start date 12/10/21; Skin check (Monday and Thursday) I = Intact, N = New, W = Wound every day-shift every Mon, Thu for skin checks start date, 12/14/21; Desitin cream 13% apply to buttock topically every shift for skin integrity, start date 1/21/22; Clotrimazole cream 2% apply to buttock topically as needed and every shift for fungal infection, start date 2/10/22; Miconazole nitrate external powder 2% (percent) apply to affected areas topically every shift for excoriation, start date 2/25/22; Clotrimazole 3 cream 2% apply to buttocks topically every shift for excoriation, start date 2/25/22; Lab: Miconazole Nitrate Power 2% apply to buttock topically every shift for skin integrity, start date 3/10/22. R4's December 2021 TAR (Treatment Administration Record) documents - Neomycin-Bacitracin-Polymyxin ointment apply to affected areas topically every shift for skin integrity, start date 12/10/21, discontinue date 12/15/22 (12/10/21 - 12/13/21 are blank); Miconazole Nitrate Powder 2% apply to affected areas topically every shift for excoriation, start date 12/10/21, discontinue date 2/23/22 (12/10/21 - 12/13/21, 12/18/21 AM, 12/24/21 AM, 12/25/22, and 12/27/22 AM are blank); Skin check (Monday and Thursday) I = Intact, N = New, W = Wound	S9999		

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S9999	Continued From page 36 every day-shift ever Mon, Thu for skin checks start date, 12/13/21, discontinue date 2/23/22 (12/13/21 and 12/27/21 are blank). R4's January 2022 TAR include - Skin check (Monday and Thursday) I = Intact, N = New, W = Wound every day-shift ever Mon, Thu for skin checks start date, 12/14/21, discontinue date 2/23/22; Desitin cream 13% apply to buttock topically every shift for skin integrity, start date 1/21/22, discontinue date 2/10/22 (1/22/22 AM, 1/25/22, 1/27/22 and 1/28/22 AM are blank); Miconazole Nitrate Powder 2% apply to affected areas topically every shift for excoriation, start date 12/10/21, discontinue date 2/23/22 (1/02//22 AM, 1/10/22 and 1/11/22 AM, 1/12/22 PM, 1/16/22 PM, 1/17/22, 1/20/22 AM, 1/22/22 AM, 1/25/22, 1/27/22 and 1/28/22 AM are blank). R4's facility record documents his first hospital admission for evaluation and treatment was on 2/23/22, with discharge back to the facility on 2/25/22. R4's in-patient discharge summary includes - Primary discharge diagnoses: altered mental status, type I diabetes insulin dependent, acute renal insufficiency, hypertension, history of congestive heart failure (CHF). Details of Hospital Stay: ...currently on Vancomycin...came to emergency room after an episode of shaking and confusion. Patient went to therapy this morning and was noted to have generalized shakiness and stiffness and confusion after shaking episodes...he has a chronic foley catheter...urine was positive for possible infection. Hospital course: Patient admitted noted to have urinary tract infection, his indwelling Foley catheter was changed, and he continued to be on antibiotics for total of 3 days...patient clinically improved and stable at the time of discharge...Physical Exam at Discharge to	S9999		

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include: ...Skin: Skin color texture, turgor normal. No rashes or lesions... Continue: ...Clotrimazole 2% cream 1 application topically 2 times daily, apply to buttock every shift and as needed for fungal infection; Miconazole nitrate 2% 1 application topical 2 times daily. R4's hospital record includes a picture of bilateral buttocks with marked redness, excoriation, and small open areas on the right buttock.

R4's February 2022 TAR includes - Skin check (Monday and Thursday) I = Intact, N = New, W = Wound every day-shift ever Mon, Thu for skin checks start date, 12/13/21, discontinue date 2/23/22 (2/03/22 and 2/07/22 are blank); Desitin cream 13% apply to buttock topically every shift for skin integrity, start date 1/21/22, discontinue date 2/10/22 (2/01/22 AM, 2/03/22 AM, 2/04/22, 2/07/22 AM, and 2/08/22 are blank); Clotrimazole cream 2% apply to buttock topically every shift for fungal infection, start date 2/10/22, discontinue 2/23/22 (2/15/22 AM, 2/18/22, and 2/19/22 PM are blank); Miconazole nitrate powder 2% apply to affected areas topically every shift for excoriation, start date 12/10/21, discontinue date 2/23/22 (2/01/22 AM, 2/03/22 AM, 2/04/22, 2/07/22 AM, 2/08/22, 2/10/22 AM, 2/15/22 AM, 2/18/22 and 2/19/22 PM are blank); Clotrimazole cream 2% apply to buttock topically as needed for fungal infection, start date 2/10/22, discontinue date 2/23/22; Miconazole nitrate external powder 2% apply to buttocks topically every shift for excoriation apply 1 application two times a day, start date 2/25/22, discontinue date 3/07/22.

The order for Clotrimazole 2% cream 1 application topically 2 times daily, apply to buttock every shift and as needed for fungal infection was not picked back up on the POS or TAR on 2/25/22.

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S9999	Continued From page 38 R4's facility record contains a wound evaluation picture, dated 3/03/22, of the bilateral buttocks measuring 1.32cm (centimeter) x 1.57cm x 1.19cm. There is no other skin or wound evaluation/assessment to accompany this picture. R4's March 2022 TAR includes - Skin check (Tuesday and Friday, repeat 1 weeks every shift 2P -10P in the evening every Tue, Fri for skin check, start date 3/01/22, discontinue date 4/09/22 (3/04/22, 3/08/22, 3/11/22, 3/15/22, 3/18/22, and 3/25/22 are blank); Clotrimazole 3 2% insert 1 application (rectally) two times a day for excoriation apply 1 application topically two times a day to buttocks and as needed for fungal infection, start date 3/09/22, discontinue date 4/09/22; Miconazole nitrate external powder 2% apply to buttocks topically every shift for excoriation apply 1 application topically two times a day, start date 2/25/22, discontinue date 3/07/22 (3/01/22, 3/02/22 and 3/03/22 AM, 3/04/22, and 3/05/22 AM are blank); Miconazole nitrate powder 2% apply to buttock topically every shift for skin integrity, start date 3/10/22, discontinue date 4/09/22. R4's April 2022 TAR includes - Skin checks Tuesday Friday. Repeat 1 weeks every shift 2P-10P in the evening every Tue, Fri for skin check, start date 3/01/22, discontinue date 4/09/22 (4/01/22 is blank); Clotrimazole 3 cream 2% insert 1 application (rectally) two times a day for excoriation apply 1 application topically two times a day to buttocks and as needed for fungal infection, start date 3/09/22, discontinue date 4/09/22 (4/01/22 PM, 4/03/22, 4/04/22 AM, 4/06/22 - 4/08/22 AM are blank); Miconazole nitrate powder 2% apply to buttock topically every shift for skin integrity, start date 3/10/22,	S9999		

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discontinue date 4/09/22 (4/04/22, 4/06/22, 4/07/22 AM are blank).

R4's most recent hospitalization, dated 4/08/22, documentation of wound history to include - pre-existing excoriation to bilateral buttocks, dated 2/23/22; MASD (moisture associated skin damage) to buttocks, dated 2/24/22; and pressure ulcer injury to bilateral buttocks, stage 1, dated 3/07/22.

On 04/22/22 at 8:15 AM, V43 (CNA) stated "(R4's) butt was pretty red," and they were applying preventative treatment. V43 stated R4 had c-diff (clostridium difficile) and R4 would spend a lot of time on the toilet. V43 stated V43 does not recall seeing any splits or open areas to R4's buttocks while V43 was caring for R4. V43 stated, "We always coated his buttocks with barrier cream when we were done with incontinence care. The nurse would put zinc oxide. Sometimes we would leave open to air." There was a 5-week period prior to R4's discharge that V43 was not on that hall, and stated when V43 was reassigned to R4's hall, R4 had already been discharged to the hospital, so V42could not speak as to what was done, and what was not during that time.

On 4/22/22 at 8:30 AM, V44 (RN) stated V44 took care of R4 on a regular basis. V44 confirmed, "(R4's) buttocks were excoriated, and we were applying treatment cream every day. He did not have any major open areas, and I applied cream to R4." V44 stated if the TARs were blank, V44 just forgot to document it, but treatment was done on the days V44 worked.

On 4/22/22 at 8:46 AM, V19 (RN/Assistant Director of Nursing/ADON) stated R4 was very

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non-compliant about staying off R4's buttocks, getting up, moving around, and maintaining different positions. R4 would say he was tired. V19 stated when V19 documented, "see wound note on 3/02 - 3/03" in R4's progress notes, V19 was referring to the wound assessment, and notes that would accompany the picture V30 took on 3/03/22 of R4's buttocks. V19 stated the only thing V19 knew about the large amount of the blanks on the TARs, were when V30 was doing treatments, V30 was marking V30's sheets off, but not documenting on the TAR, or letting the nurses know treatment had been done.

V30 was unavailable for interview regarding R4 on 4/22/22 due to being off work.

On 4/22/22 at 12:00 PM, V31 (NP) stated R4 was admitted with "diabetic wounds/amputations on the right foot, which brought (R4) here initially." When asked about the hospital documentation referring to R4's buttocks as - pre-existing excoriation to bilateral buttocks, dated 0/23/22; MASD (moisture associated skin damage) to buttocks, dated 2/24/22; and pressure ulcer injury to bilateral buttocks, stage 1, dated 3/07/22, V31 stated V31 would agree with these assessments.

On 4/22/22 at 1:00 PM, when shown the numerous holes in documentation on resident TARs, V6 (RN/ADON) stated V6 expected nursing to complete all documentation when doing treatments and sign off on the TAR, so there would be no question as to whether treatments were done.

A facility policy titled, "Measurement, Assessments of Pressure Ulcers, Wounds and Other Skin Problems" includes the following - "Policy Statement: 1. At first observation of any

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S9999	Continued From page 41 skin condition, the charge nurse or treatment nurse is responsible to measure and describe skin condition in the clinical record. 2. All Measurements will be recorded in centimeters. All ulcers (pressure, arterial, diabetic, venous) will be measured weekly, and results recorded. 3. Skin conditions other than ulcers, such as bruises, skin tears, abrasion, rashes, excoriations will be described upon initial observation and documented. Weekly measurements of these areas are not required. Policy Interpretation and Implementation: 1. Identify the type of ulcer present such as pressure, arterial, diabetic, venous, etc. Note: The clinical record should clearly support the clinical basis for the determination of the etiology of the ulcer(s) (i.e., diagnosis, signs and/or symptoms characteristics to that type of ulcer, lab, or diagnostic tests, etc.) 2. Identify the Stage or extent of tissue destruction involved. Record both the 'Deepest tissue damage' and the 'MDS Stage' on appropriate form in the appropriate box. The deepest tissue damage should describe the deepest level of tissue damage ever present since the onset of the wound. (Example: an ulcer that once had bone or muscle exposed is a Stage IV and will always have 'IV' recorded in the 'Deepest tissue damage' section for the history of the wound. However, for the MDS stage, the wound must be down staged to accurately code the MDS section M as described in the RAI manual. See Guidelines Regarding Down Staging for the MDS Coding.) PRESSURE ULCERS - Stage I ulcer: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage I may be	S9999		

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S9999	Continued From page 42 difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk) Stage II ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. * This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. *Bruising indicated suspected deep tissue injury. Stage III ulcer: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable. Stage IV ulcer: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable ulcer: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed. Further	S9999		

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	description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. Deep Tissue Injury (DTI): Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. ULCER ASSESSMENT - 1. Using a disposable ruler, obtain length and width as linear distances from wound edge to wound edge. Length will be measured vertically in relation of head to toe (12:00 to 6:00 o'clock). Width will be measured horizontally in relation of hip to hip (3:00 to 9:00 o'clock). 2. A new disposable measuring ruler will be used for each wound/skin condition. 3. To obtain depth, gently insert a clean cotton applicator to the deepest portion of the wound bed that you can see. Grasp the applicator with the gloved thumb and forefinger at the point corresponding to the wound's margin. Carefully withdraw the applicator while maintaining the position of the thumb and forefinger. Measure from the hip to the applicator to position of thumb and forefinger. NOTE: * If the wound bed depth is superficial and less than 0.1cm, the depth will be recorded as '<0.1cm'. * If the wound bed is covered with eschar or slough making the wound bed non-visible, the true depth			

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S9999	Continued From page 44 of the wounds is unknown and may be recorded as 'UND' for undeterminable. 4. Assess wound/skin condition for drainage/exudates. Record type and amount. Type: Sanguineous - thin, bright red, Serosanguineous - thin, watery, pale red to pink, Serous - thin, watery clear, Purulent - thick or thin, opaque tan to yellow, Foul Purulent - thick opaque yellow to green with offensive odor Amount: None - wound tissue dry, Scant - wound tissues moist, no measurable drainage, Small - wound tissues very moist, drainage <25% of dressing, Moderate - wound tissues wet, involves 25-75% of dressing, Large - wound tissues filled with fluid, involves >75% of dressing. 5. Assess for presence of necrotic tissue. Record type and percentage (%), Eschar - thick, leathery black crust of dead skin; can be hard or soft, Slough - String-like dead tissue, may be yellow, gray, green, or white in color, may be firmly attached, loosely adherent or non-adherent. 6. Assess for presence of Granulation tissue. Granulation tissue usually appears as beefy, red, granular, bubbly in appearance. Record in percentage (%). Epithelialization may also be described in the 'comments' section of the appropriate form. Epithelialization can appear as deep pink, then progress to pearly pink/light purple from the edges in full thickness wounds or may form islands in the wound base with partial thickness wounds. Describe location using percentage (%), clock system, or specific wound edge. 7. Assess the peri wound tissue surrounding the wound. Record findings: Healthy - intact, no problems noted, Macerated - white wrinkled from excessive moisture, Erythema - redness in color, Discolored - blue or purple, frown staining, pallor in color, etc. Other: Document in Comments section. Edema and induration, texture changes, temperature changes, rash, scar tissue, etc. 8. Assess the	S9999		

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S9999	Continued From page 45 wound edges. Record findings: Attached - wound edge is attached to the vase of the wound (no undermining or tunneling present). Unattached - wound edge is separated from the base of the wound (undermining or tunneling is present). Rolled Under - rounded or rolled under wound edge. Macerated - white wrinkled from excessive moisture. Callused - a localized build up cells of the stratum corneum due to pressure or friction. Other: describe any additional observations. 9. If undermining and/or tunneling exists, gently insert cotton tip applicator into the sites where undermining/tunneling occurs. a. The direction of undermining/tunneling shall be identified in relation to clock. View the direction of the applicator as if it were a hand of a clock (with 12 o'clock pointing to the resident's head, and 6 o'clock point to the feet). b. The depth of undermining/tunneling shall be identified using an applicator. Gently insert the cotton applicator into the undermined/tunneling area(s) Grasp the applicator where it meets the wound's edge. Pull the applicator out, place it next to a measuring guide, and document the measurement in centimeters including the direction. c. Document in centimeters using clock face on form. Example: undermining from 2 to 6 o'clock of 3 cm, tunneling at 9 pm of 3 cm. 10. Assess for odor after cleansing wound bed. Record 'Yes' for wound odor or 'No' for absence of odor. 11. Assess pain in relationship to the ulcer or peri wound tissue. If pain is present, describe. 12. Describe any problems with adherence to treatment of wound(s) and/or prevention interventions. Examples: Refusing treatment or to relieve pressure off area or turning/repositioning or nutritional supplement. Care plan should also address these situations and any alternatives that have been offered. 13. Additional wound/skin condition descriptions that may be included may	S9999		

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	IL6008528	A. BUILDING: ______ B. WING ______	C 04/25/2022

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S9999	Continued From page 46	S9999		

include but not be limited to: bone or muscle exposure, description of pain characteristics, cultures taken, adherence to treatment/prevention measures, physician notification, interventions in place etc."

A facility policy titled, "Pressure/Skin Breakdown - Clinical Protocol" effective date 2017 - Policy Specifications: "1. Document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure wound(s). 2. In addition, the nurse shall assess and document/report the following: a. Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width and depth, presence of exudates or necrotic tissue ... c. Resident's mobility status d. Current treatments, including support surfaces e. All active diagnoses 3. Examine the skin of a new admission for any alterations in skin integrity. 4. The physician will help the staff define the type (for example, arterial, stasis or diabetic ulcer) of an ulceration. 5. Identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer, or sepsis causing a catabolic state, and macerated or friable skin. 6. Document any signs/symptoms of infection, skin condition assessment, the impact of comorbid conditions on wound healing, etc. 7. The physician will authorize pertinent orders related to wound treatments, including pressure redistribution surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. a. Although poor nutritional status is associated with increased risk of pressure area development, no specific nutritional interventions

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S9999	Continued From page 47 have been proven conclusively to prevent or heal pressure areas. There are no pressure area-specific nutritional measures that should be provided routinely to those with or at risk for developing a pressure area. Nutritional supplementation should be based on realistic appraisal of need and identification of medical conditions and factors that affect appetite, weight, and overall nutritional balance. 8. The physician and/or designee will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc. 9. The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors; for example: a. Healing or Prevention Likely: The resident's underlying physical condition, prognosis, personal goals and wishes, care instructions, and ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. b. Healing or Prevention Possible: Healing may be delayed or may occur only partially; wounds may occur despite appropriate preventive efforts. c. Healing or Prevention Unlikely: The resident is likely to decline or die because of his/her overall medical instability; wounds reflect the individual's overall medical instability; an existing wound is unlikely to improve significantly; additional wounds are likely to occur despite preventive efforts. 10. As needed, the physician will help identify medical and ethical issues influencing wound healing; for example, because of end-stage heart disease or because cause-specific treatment is not advisable, not feasible, or not desired by the resident or family. a. Advance directives may limit the scope,	S9999		

Illinois Department of Public Health

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S9999	Continued From page 48 intensity, duration, and selection of various wound-related or adjunctive treatments such as a choice to forego artificial nutrition and hydration. b. Healing may be delayed or may not occur, or additional wounds may occur because of other factors which cannot be modified. c. It may be appropriate to maintain some or all the existing approaches, if they are pertinent to the resident's medical conditions, other relevant factors influencing wound development or healing, and specific treatment choices made by the resident or a substitute decision-maker." (AA)	S9999		