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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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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:

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess and implement interventions to prevent the development and reopening of pressure ulcers; failed to prevent the deterioration of an existing pressure ulcer; and failed to maintain proper functioning of the low air

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loss mattress for two (R24 and R30) of two residents in the sample of 32 reviewed for skin impairment. This deficiency resulted in R24's pressure ulcers on the left heel, right heel, sacrum, and right buttock reopening, deteriorating and increasing in sizes; and R30's healed Stage 3 pressure ulcer on the left buttock reopening.

Findings include:

R30 is a 78 year old male, admitted in the facility on 11/10/2023 with diagnoses of Hemiplegia, Unspecified Affecting Left Nondominant Side; Unspecified Sequelae of Cerebral Infarction; Pressure Ulcer of Left Buttock, Stage 3 (09/19/24); and Vascular Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic disturbance, Mood Disturbance, and Anxiety. According to MDS (Minimum Data Set) dated 11/17/23, R30's BIMS (Brief Interview for Mental Status) score was 3, which means severe cognitive impairment. Per MDS also under Sec M Skin Conditions, R30 was admitted with intact skin but at risk for developing pressure ulcers/ injuries. MDS dated 10/08/24 recorded that he (R30) rarely/never understood during interview for mental status; and had one stage 3 pressure ulcer.

R30's POS (Physician Order Sheets) recorded the following:
09/19/24 - provide low air loss mattress
10/03/24 - please provide stage 4 mattress
11/10/23 - follow preventative skin care protocol
11/10/23 - skin monitoring every other day for moderate risk

R30's doctor's wound notes recorded the following:

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10/03/24 - Stage 3 pressure wound of the left buttock full thickness, measures 2.0 cm (centimeters) x 2.0 cm x 0.1 cm. Treatment was to apply alginate calcium once daily and santyl once daily for 16 days. Mupirocin topical 2% apply once daily for 7 days; and cover with gauze island with border apply once daily for 16 days.
10/10/24 - Stage 3 pressure wound of the left buttock full thickness, measures 1.5 cm x 1.6 cm x 0.1 cm.
10/17/24 - Stage 3 pressure wound of the left buttock full thickness, measures 1.0 cm x 1.0 cm x 0.1 cm.
10/24/24 - Stage 3 pressure wound of the left buttock, resolved. Anatomic location of previously existing wound examine today: epithelialized and resolved. Follow up only as needed.

Progress notes dated 10/24/24 documented that R30's pressure ulcer on the left buttock was resolved.

On 10/29/24 at 10:45 AM, R30 was in his room, in bed. R30 was able to answer yes and no but could not understand and talk in a full conversation. V18 (Certified Nurse Assistant, CNA) was observed providing morning care on R30. R30 was observed wearing double incontinent briefs and the brief touching his skin was saturated with urine. He was using an air loss mattress. The mattress was covered with a flat sheet. On top of the flat sheet was a cloth incontinent pad. On top of the cloth incontinent pad was a white blanket folded into 4s. A wound dressing, dated 10/29 was observed on his (R30) left buttock.

On 10/29/24 at 10:40 AM, V9 (Licensed Practical Nurse, LPN) was asked regarding R30's wound dressing. V9 went to R30's room and checked the

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dressing, opened it, and stated, the pressure ulcer on the left buttock reopened. The wound appeared open, with pinkish wound bed, as observed. V14, (Registered Nurse, RN Supervisor) was also called. V14 did an assessment, stated R30's healed wound reopened.

R30's progress notes dated 10/29/24 recorded: skin checked and observed tiny reopening to the old wound in left buttock.

R30's POS (Physician Order Sheet) dated 10/29/24 documented:
Calcium Alginate External Miscellaneous apply to left buttock topically as needed for wound care.
Calcium Alginate External Miscellaneous apply to left buttock topically every night shift for wound care.
Foam dressing pad apply to left buttock topically as needed for wound management after cleansing with normal saline solution.
Foam dressing pad apply to left buttock topically every night shift for wound care after cleansing with normal saline solution.

On 10/30/24 at 9:30 AM, V10 (CNA) was asked regarding skin assessment on residents. V10 replied, "We do skin assessment during shower - head to toe, front to back, side to side. We check the skin for any issues like tears, bruising and any kind of scrapes, sore, whether there is developing skin concern or healing. If there is new skin issue, I have to tell the nurse. I also document it in the shower sheets. For low air loss mattress - there should only be one flat, top sheet on the mattress to avoid friction or pressure on the wound. Incontinence brief should only be one."

On 10/30/24 at 9:38 AM, V9 was asked regarding

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R30's pressure ulcer on the left buttock. V9 stated, "I am his regular nurse. He has the pressure ulcer on the left buttock, but it was resolved on 10/24/24. After 10/24/24, I did not receive any report from CNA regarding the reopening of his pressure ulcer on the left buttock. I just learned the reopening only yesterday when I was told by surveyor to check the dressing. There was no treatment ordered since 10/24/24 because it was healed. I spoke with V8 (Wound Care Nurse), and she got the order from V7 (Wound Doctor). He (R30) is supposed to wear a single brief. The low air loss mattress should have one flat sheet, I checked the sheets every morning when I do rounds at the start of my shift."

R30's shower skin check sheets dated 10/08/24; 10/11/24; 10/15/24; 10/18/24; 10/22/24; 10/25/24 and 10/29/24 indicated no skin issues. There were no marked areas of skin abnormalities found as documented.

On 10/30/24 at 10:18 AM, V12 (CNA) was interviewed regarding R30. V12 verbalized, "I am his regular CNA. He is alert to his name calling but unable to converse. He is totally dependent on staff for ADLs (activities of daily living). He wears brief, only one, during changing. He is at risk to develop pressure ulcers because he cannot move himself and is unable to turn. We do skin assessment anytime we do shower and changing. Any skin issue is reported to the nurse. We document skin assessment when we do shower in the sheet. Last Monday 10/28/24, he has the wound on the left buttock because there was a dressing placed. He is using low air loss mattress and there should be one flat sheet."

On 10/30/24 at 2:51 PM, V2 (Director of Nursing)

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was asked regarding pressure ulcers. V2 stated, "Staff should be repositioning following whatever orders specified for individual residents; report to nurses any skin issues and document; nurses should be rounding every shift making sure wound care is implemented as ordered. There should only be one flat sheet on the low air loss mattress because multiple paddings can cause further skin breakdown. CNAs should be doing daily skin assessments on all residents. Double briefs are not acceptable because it increases moisture enhancing skin breakdown."

On 10/30/24 at 3:52 PM, V7 (Wound Doctor) was interviewed regarding R30's pressure ulcer. V7 stated, "He had a stage 3 pressure ulcer on the left buttock and was resolved. I was not notified that the wound was reopened yesterday. Still stage 3 when reopened. Expectations on staff in managing and preventing pressure ulcer is to maintain the turning and repositioning; follow facility protocol; clean resident in a timely manner. We don't recommend the use of double briefs on residents because of increasing moisture. The less sheets the better over low air loss mattress, only the top sheet, not the fitted sheet. The use of multiple pads on the mattress decreases the functioning of the low air loss mattress. Air mattress helps relieve pressures, heat and moisture."

On 10/31/24 at 7:50 AM, V14 was asked regarding measurements of R30's reopened pressure ulcer on the left buttock on 10/29/24. V14 stated, "We did not measure it because we don't know how to do it. V8 said she will measure it when she comes to the facility."

Several attempts were made to contact V8 (Wound Nurse), but she is not available during

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the course of this survey.

According to an interview with V2 on 10/31/24 at 10:01 AM, she (V8) comes every Thursday late afternoon during wound rounds. V2 also mentioned, "Nurses on the floor are in serviced and trained on how to do wound care and wound measurements. I did the measurements today."

R30's wound care progress notes dated 10/31/24 Left buttock, Stage 3 pressure ulcer documented: 1 cm x 1 cm x 0.1 cm.

R30's care plan on skin impairment related to 10/03/24 left buttock pressure ulcer, Stage 3 documented:
Interventions:
Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.
Keep skin clean and dry.
Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. (and other similar things) to MD (Medical Doctor)
Provide treatment as ordered.

R30's low air loss manufacturer's guidelines titled "True Low Air Loss" operating instructions manual was reviewed. There were no instructions documented regarding use of sheets on the mattress.

Facility's policy (dated April 2019) titled; "Pressure Ulcer Prevention" documented (in part) but not limited to the following:
Skin care and early treatment
Skin assessment
Assessments should continue daily for residents at risk for skin breakdown. Monitor skin condition for color, moisture, temperature, integrity, and

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turgor with close attention to the bony prominences. Also observe skin areas around medical devices such as oxygen cannulas, catheters, collars and braces.

Facility's policy (dated April 2019) titled, "Risk and Skin Assessment" stated (in part) but not limited to the following:
Policy: Intact skin is the body's first line of defense. It is the policy of this facility to assess all residents for factors that place them at risk for developing pressure ulcers. It is also the policy of this facility to monitor the skin integrity of our residents for the development of wound or other skin conditions. These assessments will begin upon admission and continue throughout the resident's stay in our facility.
Procedure
II. all residents will have a visual inspection of their skin.
C. Skin check is completed on each shower day by nursing assistant staff.
D. The nursing assistant visually inspects the skin daily and with care.
1. If an area is identified, the nurse and the Stop and Watch tool may be used to communicate this information.
2. Appropriate measures will be instituted.

Facility's policy titled "Pressure Ulcer Prevention" dated April 2019, documented in part but not limited to the following:
Policy: It is the policy of this facility to implement measures to protect the resident's skin integrity and prevent skin breakdown whenever possible.

Facility's policy (undated) titled; "Wound Assessment" stated (in part) but not limited to the following:
Policy: It is the policy of this facility to complete a

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systematic, ongoing assessment of all wounds that will provide a consistent means of wound evaluation to determine the response to treatment modalities and to facilitate continuity of care and communication among staff and health care providers on an ongoing basis.
Procedure:
I. The presence of any wounds, ulcers, and/or skin abnormalities will be identified upon admission and documented on the Nursing Admission Assessment.
B. Wound documentation is initiated upon admission or identification of a wound.

R24 is a 94-year-old resident initially admitted to facility on 04/04/2019 and has diagnoses including but not limited to pressure ulcer of sacral region stage 3, pressure ulcer of right heel unstageable, pressure ulcer of left heel stage 3, rheumatoid arthritis, muscle weakness and age-related debility. Minimal Data Set (MDS) section C dated 09/11/2024 documents Brief Interview for Mental Status (BIMS) score of 14 which suggests cognition is intact. Section GG of same MDS documents resident is dependent of staff in the areas of toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and personal hygiene. Section GG also documents R24 needs substantial/maximal assistance in the areas of oral hygiene and upper body dressing.

Progress note dated 04/25/2019 documents: Note Text: Seen and exam by V7 (Wound Doctor) with orders made, dressings done, right buttocks dry and resolved. Director of Nursing and Power of Attorney notified. Coccyx almost healed, 0.2cm x 0.2 cm. Right heel left face wound no change and left heel decreased in size. Will keep monitoring.

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Progress note dated 08/16/2024 documents: Late Entry: Note Text: Upon repositioning resident in bed this morning, noted with facial grimacing upon lifting left lower extremity. Upon skin check, left heel noted with scab peeling off with skin opening noted underneath. Noted with minimal drainage. Initial treatment done post-NSS (normal saline solution) cleanse then covered with dry dressing. Procedure well tolerated by resident. BLE (bilateral lower extremities) kept elevated with pillow to offload heels. Offered pain medication however resident declined. Resident stated that she only experience pain upon touch. MD (Medical Doctor) V19 informed and agreed for wound consult. Order carried out. Informed Wound Care nurse (V8). Son aware at 08:47 AM, verbalized understanding. DON (V2) aware. AM NOD (nurse on duty) informed of the above matters.

Progress note dated 08/28/2024 documents: Note Text: IDT has agreed to do an MDS Significant Change in Status Assessment related to Stage 3 Pressure Ulcer on her left heel.

Progress note dated 08/29/2024 documents: Note Text: Seen by Wound doctor (V7) today for referral of the right heel, noted both heels swollen and with wounds, initial assessment done to right heel, with orders made, carried out, for right heel deep wound culture and sensitivity (c/s). Notified Supervisor for wound swabbing, called lab to bring wound swab for c/s, called Son and notified regarding the bilateral heels wound and aware. Notified Floor Nurse.

Progress note dated 09/05/2024 documents: Note Text: Wound nurse (V8) noted a new open sore on resident sacrum and informed writer

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(V20). Wound nurse (V8) informed that wound doctor (V7) is ordering for Calcium alginate and santyl ointment for wound dressing. Writer (V20 registered nurse) did a head-to-toe assessment on the resident to look for any other skin concerns. No new concerns noted except the new sacral sore. Wound nurse (V8) called and informed son. Informed primary doctor (V19) regarding this. V19 ordered for CBC (complete blood count), CMP (complete metabolic profile) and UA (urinalysis)& culture and V7 ordered Albumin and prealbumin levels. No other concerns. Care continuing.

Progress note dated 09/05/2024 documents: Note Text: Seen by Wound MD (V7), with orders, Pt seems not on herself and wound deteriorating, poor appetite, noted sacrum wound, notified floor Nurse to notify V19, and V2 DON (Director of Nursing) notified and aware. Called Son- but not answering his phone, left a message to call back. V7 change treatment, doxycycline ordered, deep wound c/s results still pending, awaiting, notified Floor Nurse to follow up. still with bilateral foot swollen. offload bilateral heels with boots. Reposition per facility protocol.

Progress note dated 10/24/2024 documents: Note Text: Seen by wound doctor (V7), debridement done, initial assessment done to right buttock cause by friction/moisture, with orders made, carried out, applied dressings, repositioned per facility protocol. Bilateral heels offload with foam booties, with stage 4 special mattress.

On 10/30/2024, Surveyor was provided shower skin check sheets for R24 from 09/05/2024-10/29/2024 by V2 (DON). Thirteen of seventeen shower skin check sheets document

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no skin abnormalities. The dates for these are as follows: 09/10/24, 09/17/2024, 09/20/2024, 09/24/2024, 09/27/2024, 10/01/2024, 10/04/2024, 10/08/2024, 10/11/2024, 10/15/2024, 10/18/2024, 10/22/2024, and 10/29/2024.

On 10/30/2024, Wound Evaluation & Management Summaries dated 08/22/2024-10/24/2024 were provided to surveyor by Executive Director (V1). The following dates show wound sizes increasing on these documents:
Right heel:
08/29/2024 9cm x 9cm x not measurable
09/05/2024 10cm x 9cm x not measurable
09/19/2024 10cm x 8.5cm x not measurable
09/26/2024 10.5cm x 15cm x 0.2cm
10/31/2024 10cm x 15cm x 0.7cm

Left heel:
08/29/2024 4cm x 4cm x 0.2cm
09/05/2024 5.5cm x 4.5cm x 0.2cm
10/3/2024 5cm x 4 cm x 0.2cm

Sacrum:
10/10/2024 1.8cm x 2cm x 0.2cm
10/17/2024 6cm x 3cm x 0.2cm
10/24/2024 7cm x 2.5cm x 0.2cm

Right buttocks:
10/17/2024 - resolved.
10/24/2024 1.5cm x 1.5cm x 0.2cm

On Wound Evaluation & Management Summary dated 09/05/2024 and after under plan of care documents: turn side to side in bed every 1-2 hours if able.

Order dated 10/30/2024 documents: Please do not get up patient until further order.

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CELEBRATE SENIOR LIVING NILES	7000 NORTH NEWARK NILES, IL 60714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 On 10/30/24, at 02:04 PM, Order for not getting patient up until further order was provided to surveyor dated 10/30/2024 by V1 (Executive Director). V1 explained, that she spoke to wound nurse (V8) that told her it was a verbal order given by wound doctor (V7) and that was transferred from nurse to nurse in report. When V1 was asked why the nurse did not put order in electronic medical record, V1 could not provide an answer and stated, "that is what I need to find out". At the same time surveyor was also provided document with this order written on paper and dated 08/29/2024. Order dated 08/29/2024 documents: Reposition every 1-2 hours if able every shift. On 10/29/24, at 09:55 AM, Surveyor went to R24's room. R24 in bed wearing gown positioned on back with head of bed raised to approximately 45 degrees. R24 has fabric incontinence pad underneath buttocks on top of flat sheet over low air loss mattress. Heel protector boots noted on both heels. On 10/29/24, at 10:19 AM, Surveyor went with Licensed Practical Nurse (LPN) V3 and Certified Nursing Assistant (CNA) V4 to observe wounds for R24. R24 noted to be positioned on back with head of bed elevated to approximately 45 degrees. R24 noted to have on heel protectors on both feet and legs on pillows x 2. Right foot noted to have large scab to top left of foot and wound to heel on left foot. V3 stated, it is unstageable and has tunneling. Left heel has stage 3 pressure ulcer. She has not got up out of bed for 1 week. I believe it was the wound nurse (V8) that does not want her to get up. I think she got them less than 3 months ago. Before R24 was propelling in	S9999		

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wheelchair to dining room. Maybe from propelling in wheelchair R24 got these. R24 was up every day before this happened. R24 is not on hospice. R24 also has a wound stage 3 on her sacrum and right buttocks. All the resident who have wounds have their position changed every 2 hours. V4 CNA stated, "I change her position 2 times on my shift. After breakfast and after lunch". V3 stated, "that may be why they are getting worse". V4 stated, I only change R24 two times per my shift unless R24 calls me. R24 knows when she has a bowel movement and can use call light. We do not check every two hours, sometimes we check but it is mainly two times per my shift. My shift is 6 am - 2:30 pm. V3 stated, the wound to the right buttocks is getting worse. I will tell the wound nurse V8. From the last time I seen all her wounds they are all getting worse except the left heel is getting better. The wound nurse (V8) is the one documenting these wounds. R24 noted to have sheet on air mattress and green fabric incontinence pad underneath buttocks area.

On 10/30/24, at 09:27 AM, V2 (DON) went in room to give resident fresh water. Surveyor noted R24 was positioned laying on back. Bed covered with flat sheet and folded sheet. Folded sheet was folded in quarters so 4 layers of pull sheet under resident as well as flat full sheet. Pillow noted under knees and pillow under heels with heel protecting boots on. R24 stated they have not changed her position or brief yet this morning.

On 10/30/24, at 09:34 AM, V3 (LPN) stated, like yesterday green pull sheet should be not on the air mattress. Surveyor asked V3 what should be on the bed with air mattress. V3 stated, only one flat sheet should be on air mattress. There should be no pull sheet or any other item of material under resident. You lose the benefits of the air

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mattress if you have more layers. If the CNA's do what they are supposed to do, we will prevent the issues like this of resident having wounds or them getting worse. This is my point of view only.

On 10/30/24, at 09:39 AM, V3 LPN went with surveyor into R24's room and showed V3 the resident positioned on back and on a pull sheet folded in quarters on top of flat sheet on air mattress. V3 stated, R24 should not be positioned on back, R24 should not have pull sheet or have a pillow under heels because R24 has boots on already. Do you see how many layers are underneath R24? That is wrong.

On 10/30/24, at 09:41 AM, V16 (CNA) stated, I put the pull sheet underneath R24. I also put R24 on her back. I put R24's heels on a pillow as well. V3 and V16 repositioned resident to be on right side and removed pull sheet from underneath R24. V3 also removed pillow from underneath resident heels.

On 10/30/24, at 09:48 AM, V3 stated, it is hard when you have different CNA's. I have to remind them all of the time. Poor residents.

On 10/30/24, at 09:50 AM, V16 CNA stated, we put pull sheets under residents on air mattresses to help move them. I put the pillow under R24's heels to protect the heels. I position resident every two hours from right side, back and left side. There is nothing in the computer to say what side to position resident. When I go in to reposition R24 I just change to a different position than R24 was in.

On 10/30/24, at 10:15 AM, V5 CNA provided incontinence care to R24. V5 did not wear a gown. V5 wore gloves. R24 was positioned on

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her right side with pillow under knees and back, and heel protector boots on bilateral feet. Call light was attached to blanket covering resident and was in reach.

On 10/30/24, at 10:26 AM, V14 Registered Nurse (RN) Supervisor stated, CNAs should check all residents every 2 hours for incontinence and keep them clean and dry. Those who are in bed and at risk for pressure injury should be repositioned every two hours. All these high-risk residents should have a clock on the wall indicating what way to turn them. For residents on the air mattresses there should be only a flat sheet used. No fitted sheet, no pads, no pull sheets just the flat sheet should be on the air mattresses. This allows the air to flow freely. If these items are used the air mattress will be ineffective. Air mattresses are used for relieving the pressure for residents at high risk for pressure ulcers or so pressure ulcers do not get worse. It also helps with healing pressure ulcers. The staff can use pull sheet for additional support if they can't use only the flat sheet to move resident but must pull it out and not leave under resident.

On 10/30/24, at 10:42 AM, R24 was still positioned on right side and surveyor maintained visual observation of R24's room from hallway.

On 10/30/24, at 11:10 AM, Resident remained positioned on right side.

On 10/30/24, at 12:15 PM, V3 (LPN) stated, R24 has been in bed for more than a week now because of her wounds. That came from wound care. Surveyor asked V3 to give surveyor a copy of the order to keep resident in bed due to wounds.

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S9999	Continued From page 17 On 10/30/24, at 12:21 PM, R24 observed to have not been repositioned since incontinence care was provided at 10:15 AM. Surveyor has been observing R24 in hallway since 9:39 AM. Resident has been positioned on right side since 09:41 AM prior to incontinence care and again after incontinence care. On 10/30/24, at 12:42 PM, R24 remains on right side position in the bed. Surveyor was in direct vision of R24 from 10:15 AM when incontinence care was done until 12:42 PM when surveyor stops observing R24's room. 2 hours and 27 minutes passed with R24 positioned on right side. On 10/30/24, at 01:10 PM, Surveyor returned to R24's room and R24 was noted to be positioned on right side in bed. On 10/30/2024, Surveyor was provided with Treatment Administration Record for R24 for the month October 2024. October 30, 2024, documents V3 (LPN) charting that R24 was repositioned every 1-2 hours if able every shift. On 10/30/24, at 02:20 PM, V2 (DON) stated, nurses document that positioning is done on residents, so they check it off in the electronic medical record. CNAs are checking it off on their tasks as well. I cannot print out the CNA tasks but can print out the nursing documentation showing they are charting on repositioning R24. Surveyor told V2 what observations were for R24 repositioning. Surveyor asked V2, how do you monitor that orders are being followed? V2 stated, we do rounds. Me and the nursing supervisors constantly and we are helping out. Surveyor asked V2 to pull up orders for repositioning for R24. V2 stated, order dated	S9999		

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8/29/24 documents reposition every 1-2 hours if able. Anything over 2 hours would be unacceptable. It should be every 1-2 hours and as needed. This would be a write up and re-education/in-service since the orders were not followed. Yearly evaluations for CNA's are done. We do annual competency which are mandatory on in-services and throughout the year we do falls, safety, peri care, or whatever comes up. We do a minimum of one a month. Surveyor asked V2 what interventions are in place for preventing further worsening of wounds and promote healing. R24 is followed by dietician and staff should be off loading heels. R24 should have heel protecting boots and they should not be propped up on a pillow, if using a pillow, it should be placed under the knees/leg for support but not under heels. R24 has juven ordered daily for wound healing. R24 is getting ensure for protein TID. R24 is on an air mattress. My expectations for staff regarding air mattress should have a flat sheet on keeping it clean and dry. It is not ok to have one pad underneath resident on air mattress with flat sheet. Staff should not have a folded sheet underneath R24 on top of flat sheet. Staff should be using enhanced barrier precautions which is gown and gloves for wound care. Staff should be wearing gown and gloves for incontinence care. Surveyor asked V2 what is causing her wounds to get worse and how did they happen. V2 stated, R24 is wheelchair bound and does not walk anymore. R24 does not wear shoes and only wears socks. R24 was in her wheelchair in her room most of the day. Occasional activity, abnormal posture, and that as well as cardiac health caused her wounds. Surveyor asked V2 how did wounds on heels get that big without anyone noticing? V2 stated, I do not know how to answer that. Surveyor asked what the expectation of staff on skin checks is.

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V2 stated, daily skin checks should be done by nurses and CNA's while providing care. On shower days CNAs should be doing assessment and letting nurse know of any new skin issues. Surveyor showed V2 the shower sheets provided for October 2024 that document on 8 separate skin checks resident has no skin issues and asked if this was acceptable. V2 stated, the shower sheets you have for October that shows no skin issues are unacceptable. CNAs should be marking any skin areas on shower sheets. I will get you shower sheets from 9/5-10/1/24. Regarding pressure ulcer, CNA's when notice any new skin issues and notify nurses and document. Nurses should be rounding every shift making sure they are doing dressing changes. Wound care is done sometimes daily, and they should be making sure wound care is implemented as ordered. Low air loss mattress should only have one flat sheet. Multiple padding can cause further skin breakdown. CNAs should be rounding every 2 hours and change when needed. No pad just a flat sheet and a diaper on air mattress. CNAs should be doing daily skin assessments on all residents. Surveyor asked V2 to provide these documents for the last month. V2 stated she will look to see what she has to provide to surveyor.

On 10/31/2024, at 12:24 PM, V1 (Administrator) stated, per V2 (DON) CNAs are monitoring skin daily upon providing care and notifying a nurse if there is a skin change. There is no additional documentation.

On 10/30/24, at 03:51 PM, V7 Wound Care Doctor stated, I oversee the wounds in the facility. Surveyor asked V7 what expectations of staff are to prevent wound reopening. V7 stated, offloading, clean patient in timely manner, turning and repositioning. The less layers the better for

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an air loss mattress is better. Multiple padding on air mattress decreases the functioning of the low air loss mattress. Use of low air loss mattress is supposed to help relieve pressure and heat and moisture. When there are multiple layers, it defeats the purpose of the mattress. My expectation of staff should be following skin protocol. Regarding R24, I am not exactly sure what caused her pressure ulcers. R24 has had wounds on her heels before and they healed and reopened up. R24 recently had an infection pneumonia or UTI that may have contributed to reopening. R24 doesn't really move that much and the wound on heals have scar tissue that I have debrided. Surveyor told V7 of observations of R24 regarding positioning, heels on pillow with heel protectors, and multiple layers on air mattress. V7 stated, multiple layers on low air loss mattress contributes to wound worsening and not healing. Not following the position turning schedule also contributes to wound getting worse and not healing properly. Heel boots should not have a pillow under heels as it defeats the purpose of the boots.

Risk and Skin Assessment Policy dated April 2019 documents:
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II. C. Skin check is completed on each shower day by nursing assistant staff.
1. Staff document the skin check
2. If an area is identified, the nurse is notified, and the Stop and Watch tool may be used to communicate this information.
3. Appropriate measures will be instituted.
D. The nursing assistant visually inspects the skin daily with care.
1. If an area is identified, the nurses is notified, and the Stop and Watch tool may be used to communicate this information

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S9999	Continued From page 21 2. Appropriate measures will be instituted. Pressure Ulcer Prevention Policy dated April 2019 documents: Page 6 Prevention I.A. 1. Residents with sensory deficits will be reminded to turn and reposition at least every 2 hours in the bed ore every fifteen minutes to an hour when up in the chair as appropriate. 2. Residents who are unable to turn and reposition independently will be assisted to turn and reposition every two hours or as appropriate. Page 23 Skin Care and Early Treatment Skin Assessment Complete Skin Assessment - The complete skin assessment is an integral part of the pressure Ulcer Prevention Program. It is through these inspections that early skin problems can be identified, and interventions implemented. Page 25 Mechanical Loading Pressure may develop from positioning as well as the use of medical devices. Pressure may develop form the use of nasal cannulas, casts, braces, cervical collars, positioning boots, or other medical devices. Monitor the device for proper placement to avoid pressure on surrounding tissue. (B)	S9999		