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| S 000 | Initial Comments<br><br>Complaint Investigation: #2542335/IL188313 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.1010h)<br>300.1210a)<br>300.1210b)<br>300.1210d)5)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1010 Medical Care Policies<br><br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such | S9999 | | |

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

Section 300.1210 General Requirements for Nursing and Personal Care

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

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat

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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 were not met as evidenced by:

Based on observation, interview and record review the facility failed to assess resident's skin upon admission, failed to provide ongoing assessments, failed to follow/update physician's treatment orders, failed to complete physician ordered pressure ulcer treatments and failed to put interventions in place to prevent skin breakdown for 3 of 3 residents (R1, R2 and R3) reviewed for pressure ulcers in a sample of 3. This failure resulted in R2 developing a deep tissue injury (DTI) to R2's right hip which worsened by increasing in size.

evolved to an unstageable pressure ulcer and the left hip pressure ulcer a DTI evolved to a Stage 3 pressure ulcer.

Findings include:

1. R2's Undated Face Sheet, documented he was initially admitted to the facility on 10/4/2022. No diagnosis of pressure ulcers was documented.

R2's Care Plan, dated 10/28/2022 documents, "Resident is at risk for skin complications r/t

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(related to) unspecified dementia without behavioral disturbances, altered mental status. 12/27 (year not documented) right hip treatment in progress res (resident) follow up with in house wound NP. 2/15 (year not documented) treatment in progress to hip. Goal: will maintain adequate skin integrity throughout next review. Interventions: skin assessment weekly 10/28/2022, ensure proper body alignment 12/14/2024, increase protein intake 12/14/2024, Prostate 30 milliliters (ml) BID (twice a day) 1/8/2025 and low air loss mattress 3/7/2025."

R2's Minimum Data Set (MDS) dated 11/25/2024 documents resident is rarely/never understood, at risk for pressure ulcers but does not have any unhealed pressure ulcers. Pressure reducing device for chair and bed.

R2's Skin Screen dated 12/14/2024 documents right iliac crest (hip) reddened area noted. Actions taken notified treatment nurse of area and wound NP (nurse practitioner) made aware. Foam dressing reapplied.

R2's Progress Note, dated 12/14/2024 at 7:06 PM documents, "No open areas noted."

R2's Readmission Braden Scale for Predicting Pressure Sore Risk, dated 12/14/2024 documents 11 - very high risk.

R2's Progress Note, dated 12/16/2024 at 1:38 PM documents, "Res (Resident) noted to have reddened area to right hip, area cleansed, and foam dressing applied, res (resident) voiced no c/o (complaint of) pain or discomfort. DON (Director of Nurses) notified, POA (Power of Attorney) notified will continue to monitor wound np (nurse practitioner) notified." There was no

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other description of R2's pressure ulcer documented.

R2's Progress Note, dated 12/20/2024 documents, "Res was seen by wound care nurse and wound NP treatment as ordered, area stable and no s/s (signs or symptoms) of infection noted, plan of care continue." There was no description of R2's pressure ulcer documented.

R2's Medical Record had no documentation from the Wound NP regarding the assessment or description of R2's pressure ulcers on 12/20/2024.

R2's Wound Assessment Report, dated 12/27/2024 documents right hip pressure/DTI (deep tissue injury) measured: 1.1 cm (centimeters) x 0.6 cm, wound status: reopened, acquired in house, 100% epithelial, exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: none, exudate description: none, odor post cleansing: none. Treatment: weekly and PRN cleanse with wound cleanser, skin prep and hydrocolloid."

The National Pressure Injury Advisory Panel (NPIAP) website defines Deep Tissue Pressure Injury as the following" Intact or non-intact skin with localized area of persistent non-blanchable deep red, marron, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often preceded skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and or/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extend of tissue

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injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are not visible, this indicates full thickness pressure injury (Unstageable, Stage 2 or Stage 4)."

R2's Medical Record didn't document a Wound Assessment Report or weekly skin assessment from 12/28/2024 through 1/16/2025.

On 3/19/2025 at 11:00 AM V7, Infection Preventionist/Former Wound Nurse stated she was the facility wound nurse from October 2024 through December 2024. V7 recalled R2's right hip was red on 12/20/2024 and the nurse practitioner didn't write a treatment order or document the reddened area because R2's right hip wasn't open at that time. When she left as the wound nurse at the end of December 2024 staff were cleansing R2's right hip and applying a bordered foam dressing to protect his skin from breaking down. V7 wasn't aware there was a new wound treatment was ordered for R2's right hip on 12/27/2024 because she was promoted to a different nurse position at the facility.

R2's Wound Assessment Report, dated 1/17/2025 documents right hip pressure/DTI, measured: 0.7 cm x 0.6 cm x 0.1 cm, wound status: improved with delayed wound closure, acquired in house, 100% epithelial, exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: none, exudate description: none, odor post cleansing: none. Treatment: weekly and PRN cleanse with wound cleanser, skin prep and hydrocolloid.

R2's Wound Assessment Report, dated

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1/24/2025 documents right hip unstageable pressure ulcer, measured 3.5 cm x 3.8 cm x 0.1 cm, wound status: worsening, 40% epithelial, 10% granulation, 50% eschar, exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: moderate, exudate description: serosanguineous, odor post cleansing: mild. Treatment: daily and PRN cleanse with wound cleanser, SSD, collagen hydrogel, collagen particles and bordered foam dressing.

R2's Physician's Order Sheet (POS) dated 12/19/2024 through 1/30/2025 documents right hip pressure ulcer treatment cleanse with wound cleanser, apply foam border dressing everyday shift for prophylaxis. The facility failed to change the pressure ulcer treatment orders from the wound nurse practitioner on the Wound Assessment Report dated 12/27/2024 and 1/24/2025.

R2's TAR (Treatment Administration Record) dated 12/19/2024 through 1/30/2025 documents right hip pressure ulcer staff documented treatment was administered per the POS. This was not the correct wound treatment per the wound nurse practitioner's wound assessment report dated 12/27/2024 through 1/24/2025.

R2's Medical Record documents from 12/27/2024 through 1/30/2025 failed to change the right hip pressure ulcer treatment order from the wound nurse practitioner from 12/27/2024 through 1/30/2025.

R2's Wound Assessment Report, dated 1/31/2025 documents right hip unstageable pressure ulcer, measured 3.5 cm x 3.8 cm x 0.1 cm, wound status: stable eschar, 100% eschar,

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exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: moderate, exudate description: serosanguineous, odor post cleansing: mild. Treatment: daily and PRN cleanse with wound cleanser, medical grade honey and bordered foam dressing.

R2's Medical Record documents no Wound Assessment Report or weekly skin assessment dated 2/1/2025 through 2/13/2025.

R2's POS, dated 2/4/2025 through 2/17/2025 documents a new physician's order left hip cleanse wound cleanser and apply bordered foam dressing everyday shift. There is no documentation of any pressure ulcer to R2's left hip at that time.

R2's Wound Assessment Report, dated 2/14/2025 documents right hip unstageable pressure ulcer, measured 3.5 cm x 3.8 cm x 0.1 cm, wound status: stable eschar, 30% granulation, 70% eschar, exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: moderate, exudate description: serosanguineous, odor post cleansing: mild. Treatment: daily and PRN cleanse with wound cleanser, Santyl and bordered foam dressing.

R2's Medical Record no documentation R2's left hip skin assessment regarding the physician's order dated 2/4/2025 through 2/17/2025.

R2's POS dated 2/18/2025 through 2/25/2025 documents a new physician's order cleanse right hip with wound cleanser, apply Santyl and cover with a dry dressing. This was a wound nurse practitioner treatment order from the wound

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assessment report dated 2/14/2025. The POS was not updated with the new wound nurse practitioner treatment order for 4 days.

R2's POS, dated 2/18/2025 through 2/24/2025 documents a new physician's order to left hip: cleanse with wound cleanser and apply Santyl to wound bed and cover with bordered foam dressing as needed for left hip wound and everyday shift for left hip.

R2's TAR, dated 2/18/2025 through 2/24/2025 staff documented R2's treatment to the right hip was administered per physician's orders, expect a blank box dated 2/24/2025.

R2's MDS, dated 2/20/2025 documents resident rarely/never understood, resident is at risk for developing pressure ulcers and resident has 1 unhealed unstageable pressure ulcer. Pressure reducing device for chair and bed, pressure ulcer care, application of nonsurgical dressings and applications of ointments/medications applied.

R2's Wound Assessment Report, dated 2/21/2025 documents right hip unstageable pressure ulcer, measured 4.5 cm x 5.7 cm x 0.7 cm, wound status: improving with delayed wound closure, 10% granulation, 90% slough, exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: moderate, exudate description: serosanguineous, odor post cleansing: mild. Treatment: daily and PRN cleanse with wound cleanser, SSD, collagen hydrogel, collagen particles, calcium alginate and a bordered foam dressing.

R2's Medical Record no documentation R2's left hip skin assessment regarding the physician's

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| S9999 | Continued From page 9<br>order dated 2/17/2025 through 2/24/2025.<br><br>R2's POS dated 2/25/2025 documents a new physician's order cleanse right hip with wound cleanser, apply SSD, collagen, hydrogel, collagen particles, calcium alginate, cover with bordered gauze everyday shift. This is from the Wound Assessment Report, dated 2/21/2025. The POS was not updated with the new wound nurse practitioner treatment order for 4 days.<br><br>R2's TAR dated 2/25/2025 through 3/7/2025 staff documented right hip cleanse with wound cleanser, apply SSD, collagen, hydrogel, collagen particles, calcium alginate, cover with bordered gauze everyday shift.<br><br>R2's Wound Assessment Report, dated 2/28/2025 documents right hip unstageable pressure ulcer, measured 4.8 cm x 5.4 cm x 1.1 cm, wound status: improving with delayed wound closure, 20% granulation,80% slough, exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: moderate, exudate description: serosanguineous, odor post cleansing: mild. Treatment: daily and PRN cleanse with 0.125% Dakin's solution, SSD, collagen hydrogel, collagen particles, calcium alginate, silicone bordered superabsorb dressing. New left hip pressure/DTI documented date acquired in house 2/28/2025 measured 1.5 cm x 0.7 cm 100% epithelial, exposed tissue: epithelium and dermis. Wound edges: attached, periwound: fragile and scarring. No exudate, no odor post cleansing. Treatment: 3 times per week and PRN cleanse with normal saline, skin prep and bordered foam dressing.<br><br>R2's POS dated 2/25/2025 through 2/28/2025 | S9999 | | |

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documented no physician's order to treat R2's left hip pressure ulcer.

R2's TAR dated 2/25/2025 through 2/28/2025 no documentation staff administered a treatment to R2's left hip pressure ulcer.

R2's POS, dated 3/1/2025 through 3/6/2025 no physician's order to treat R2's left hip pressure ulcer.

R2's TAR, dated 3/1/2025 through 3/6/2025 no staff documentation R2's left hip pressure ulcer treatment was administered.

R2's POS dated 3/7/2025 through 3/13/2025 documents a new physician's order left hip: cleanse with normal saline apply calcium alginate every 24 hours and one time a day every Monday, Wednesday, Friday.

R2's TAR dated 3/10/2025 through 3/13/2025 staff documented left hip cleanse with normal saline and apply calcium alginate one time a day every Mon, Wed, Fri treatment was administered.

R2's POS, dated 3/8/2025 documents a new physician's order right hip cleanse with Dakin's solution, moisten gauze, silicone border superabsorbent dressing every day shift. This treatment order was from the Wound Assessment Report, dated 2/28/2025. The POS was not updated with the new wound nurse practitioner treatment order for 8 days.

R2's Wound Assessment Report, dated 3/7/2025 documents right hip unstageable pressure ulcer, measured 4.6 cm x 6.5 cm x 1.5 cm, wound status: worsening, undermining from 2 o'clock to 7 o'clock, 1.1 cm, 20% granulation, 80% slough,

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exposed tissue: epithelium, wound edges: attached, periwound: fragile erythema, scarring, exudate amount: heavy, exudate description: seropurulent, odor post cleansing: malodorous. Treatment: daily and PRN cleanse with 0.125% Dakin's solution, silicone bordered superabsorb dressing. Left hip stage 3 pressure ulcer measured 1.0 cm x .5 cm x 0.1 cm, wound status: stable, 80% granulation, 20% slough, exposed tissue: epithelium, dermis and subcutaneous, wound edges: attached, periwound: fragile and scarring, exudate amount: scant, exudate description: serosanguineous, odor post cleansing: none. Treatment order: 3 times a week and PRN cleanse with normal saline, calcium alginate and bordered gauze.

R2's POS, dated 3/8/2025 documents a new physician's order for right hip treatment daily and PRN cleanse with 0.125% Dakin's solution, silicone bordered superaborb dressing.

R2's TAR, dated 3/8/2025 through 3/13/2025 staff documented right hip treatment administered per physician's orders.

On 3/20/2025 at 3:20 PM V17, Wound NP stated she expects staff to do a head-to-toe skin assessment as soon as possible within 72 hours of admission. As soon as staff are aware of an open area/pressure ulcer staff should notify the wound NP within 2-3 hours to get treatment order. There is a standing order for pressure ulcers which is cleanse the area with normal saline and apply a dry dressing. When she is at the facility she communicates with the wound nurse and/or charge nurse to let them know of wound treatment changes while she is at the facility, and she expected the wound treatment changes to go into effect immediately unless the

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primary physician doesn't agree with the wound treatment order then the facility should notify her within 24 hours so she can get a new treatment order in place. When a resident has a pressure ulcer, she expects staff to administer the current pressure ulcer treatment and for staff to follow all physician's orders. V17 stated she wasn't aware staff didn't follow wound treatment orders for R2 and that he went without wound treatment as well. V17 stated she expected a treatment to be in place at all times and if there wasn't a wound treatment ordered staff should have notified her so she could get a treatment ordered as soon as possible. Staff not changing/updating physician's wound treatment order could lead to the deterioration of the pressure ulcer(s.) V17 expected facility staff to have interventions in place to prevent pressure ulcers from getting worse and the facility should have had a specialty air loss mattress for residents with a DTI or stage 3 pressure ulcer to help in reliving pressure.

On 3/20/2025 at 3:40 PM V18, Nurse Practitioner stated she's never had to approve of the wound nurse practitioner's treatment orders, the wound nurse practitioner writes orders for wounds and the facility should implement the treatment orders as soon as possible. The facility not following or changing wound treatment order could lead to the deterioration of the pressure ulcer. V18 wasn't aware the facility didn't administer the correct pressure ulcer treatment orders for R2 or that the facility failed to ensure treatment orders were ordered for pressure ulcers for R2.

2. R1's Undated Face Sheet documents she was initially admitted to the facility on 3/10/2025 with no diagnosis of pressure ulcer documented. R1's Braden Scale for Predicting Pressure Sore Risk, dated 3/10/2025 documents she is very

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high risk for pressure ulcers.

R1's Progress Note, dated 3/10/2025 at 5:00 PM documents, resident arrived to facility via ambulance and has open area to coccyx.

R1's Undated Care Plan, no documentation that she has a pressure ulcer on her coccyx or interventions to prevent it from getting worse.

R1's Skin Screen, dated 3/11/2025 documents open area on coccyx no measurements or wound assessment documented.

R1's Medical Record documents no assessment of pressure ulcer on coccyx from 3/10/2025 through 3/13/2025.

R1's Wound Assessment Report, dated 3/14/2025 documents present on admission stage 4 pressure ulcer on R1's sacrum measured 5.5 cm x 10 cm x 3.5 cm with 30% granulation, 40% slough, 30% eschar exposed tissue: hypergranulation, epithelium, dermis subcutaneous and bone. Wound edges: attached, periwound: fragile, exudate amount: heavy, exudate description: purulent, odor post cleansing: malodorous.
R1's Medical Record documents no physician's treatment order dated 3/10/2025 or 3/11/2025.

R1's POS, dated 3/12/2025 documents a treatment order for coccyx: cleanse with Dakin's and apply Dakin's soaked gauze and cover with dry dressing.

R1's TAR, dated 3/2025 staff documented treatment to coccyx pressure ulcer per physician's orders.

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On 3/19/2025 at 9:40 AM V5, Registered Nurse, RN entered R1's room and rolled her to her left side and showed a large intact dressing on her coccyx. V5 stated he just administered pressure ulcer treatment to (R1's) coccyx.

3. R3's Undated Face Sheet documents he was initially admitted to the facility on 3/4/2025 with no diagnosis of a pressure ulcer.

R3's MDS dated 3/11/2025 documents BIMS 11, resident at risk for developing pressure ulcers and has one unhealed pressure ulcer. Pressure reducing device for bed and pressure ulcer care.

R3's Admission Braden Scale for Predicting Pressure Sore Risk, dated 3/4/2025 was 14 - moderate risk.

R3's Nurse Progress Note, dated 3/4/2025 at 6:10 PM documents, "resident arrived to the facility via EMS (emergency medical services) services. Resident has wound to right shin."

R3's Skin Screen, dated 3/5/2025 documents right calf reddened area full thickness. No further assessment documented.

R3's Medical Record dated 3/4/2025 through 3/6/2025 no documentation of wound/pressure ulcer on right calf.

R3's Wound Assessment Report, dated 3/7/2025 documents right lateral calf stage 3 pressure ulcer present on admission measured 5.3 cm x 6.9 cm x 0.2 cm and wound tissue was epithelium, dermis and subcutaneous. Wound edges: attached, periwound: fragile and scarring, exudate amount: scant, exudate description: serosanguineous, no post odor cleansing.

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Treatment order: daily and PRN: cleanse with wound cleanser, xeroform and bordered gauze dressing.

R3's POS dated 3/4/2025 through 3/8/2025 documents no treatment orders for wound/pressure ulcer on right calf.

R3's POS, dated 3/9/2025 documents cleanse right calf with wound cleanser, apply xeroform and dry dressing one time a day for wound care.

R3's TAR, dated 3/9/2025 through 3/19/2025 staff documented right calf pressure ulcer treatment per physician's orders.

On 3/19/2025 at 10:30 AM V3, Wound Nurse/Assistant Director of Nurses (ADON) stated she started working as the facility wound nurse 2 weeks ago. When a resident is admitted to the facility, she expects staff to document if the resident has open areas/wounds in the nurse progress notes, floor nurses are not expected to document wound assessments she follows up on all admissions residents daily, she typically works Monday through Friday from 7:00 AM through 5:00 PM. She expects the admission skin assessment to be documented in the nurse progress notes within 4-6 hours of the resident being admitted to the facility. She expects the admitting floor nurse to document if there is an open area and to what it is located. Floor nurses are not expected to document an assessment including measurements or a wound bed assessment. She reviews new resident admission documentation and residents with open areas/wounds the facility has a standing order for wet to dry dressing until the wound nurse practitioner rounds and assesses the resident's wound on Fridays. V3 doesn't assess

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wounds or measure them at all, the wound nurse practitioner does that on Fridays this does not matter what day the resident is admitted to the facility the wounds will not be assessed until Friday. V3 stated if she is not at the facility when a resident is admitted she does a triple check through their medical record the next day is works and she checks the resident's admission nurse progress note, physician's orders for wound treatment and the resident's care plan to ensure it addresses wounds.

On 3/25/2025 at 11:48 AM V2, Director of Nursing (DON), stated she started working at the facility as the DON 3 weeks ago and was the ADON for approximately 3 weeks prior to that. V2 stated skin assessment should done within 1 hour of arrival to the facility because you want to know if resident has open areas/pressure ulcers. Staff should document in nurse notes exactly what they see what they see what it is drainage, odor present, use measuring tape to measure wound and document assessment of the wound bed in the nurse's notes or the skin screen form. Staff should notify the facility nurse and/or the wound np that rounds every Friday. V2 doesn't except staff to measure the wound/pressure ulcer unless they have the proper measuring tape, and they are trained to measure the wound to ensure accuracy. Staff should obtain a treatment in place for a pressure ulcer border foam dressing. Depending on wound/pressure ulcer after wound nurse assesses resident's skin, she notifies the wound NP and gets a proper treatment in place. A treatment is expected to be ordered 24 hours of resident being admitted to the facility. Wound NP does rounds every Friday and sends report that night and facility wound nurse gets the facility wound treatment report and changes the orders the same night and the new treatment should

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start the next day. V2 expects staff to follow facility policies and physician's orders. Restorative and therapy are updated at the Nutrition Assessment Risk (NARs) which assess all residents including residents with pressure ulcers and they are the ones who recommend a resident receive a low air loss mattress. V1 stated she wasn't aware residents including R1 and R3 were admitted to the facility with pressure ulcers not being thoroughly documented, no pressure ulcer treatment in place and that resident's with pressure ulcers care plan not updated, physician's orders not being followed, and physician's orders not being changed/updated. She didn't know why these nurse responsibilities were not carried out.

On 3/19/2025 at 11:40 AM V1, Administrator stated when a resident is admitted to the facility the wound nurse is responsible for documenting a pressure ulcer assessment including measurement and what the wound bed looks like and then the wound nurse notifies the wound nurse practitioner, and they round every Friday. A treatment order is ordered from the wound nurse practitioner initially until the pressure ulcer is assessed on Friday and then the pressure ulcer treatment maybe changed per the wound nurse practitioner's recommendations. V1 stated she wasn't aware nursing staff failed to document R1's and R3's pressure ulcers upon admission to the facility.

The Facility's Admission/Re-Admission Policy revision date 1/2023, documents all new admissions within 24 hours of admission have NRSG: Admission Observation.

The Facility's Physician's Orders Policy, revision date 2/2024 documents each medication order is

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documented in the resident's medial record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet in the computer and the MAR or TAR. The following steps are initiated to complete documentation: clarify the order, enter the orders with administration schedule in the computer and transmit to pharmacy and if order is replacing a previous order d/c (discontinue) previous order in the computer.

The Facility's Skin Care Prevention Policy, revision date 5/2021 documents all residents will receive appropriate care to decrease the risk of skin breakdown. The nursing department will review all new admission/re-admissions to put a plan in place for prevention based on the resident's activity level, comorbidities, mental status, risk assessment and other pertinent information. Dependent residents will be assessed during care for any changes in skin condition including redness (non-blanching erythema) and this will be reported to the nurse. The nurse is responsible for alerting the health care provider. All residents will be evaluated for changes in their skin condition weekly. All residents unable to reposition themselves will be repositioned as needed, based on a person-centered approach per the resident's plan of care. Educate the resident and resident representative regarding pressure ulcer prevention and treatment as appropriate.

The Facility's Skin Management: Pressure Injury Treatment/General Wound Treatment Policy revision date 5/2021, documents routine and PRN treatments in the treatment administration record. Document all significant observations in the nursing progress note. Pressure injuries will be evaluated, and the following areas

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| S9999 | Continued From page 19<br><br>documented weekly (minimum every 7 days) location, stage, size, depth, presence and location (based on the clock) of undermining/tunneling/sinus tract, exudate: type, color, and approximate amount, pain: nature and frequency, wound bed: color and type of tissue/character including evidence of healing (granulation tissue) or necrosis. Description of wound edges and surrounding tissues (rolled edges, redness, maceration, etc.) The staff will notify the wound nurse upon identification of skin impairment. If the wound nurse is not available, the staff should alert the health care provider for treatment orders. When the wound care team assesses the resident, they will take a picture, measure the wound, review the orders, and update any notes and care plans as appropriate. If a wound shows no signs of healing after three weeks, a reevaluation of the treatment plan including determining whether to continue or modify the current interventions is done. If the decision is made to retain the current regimen, documentation of the rationale for continuing the current plan will occur.<br><br>(B) | S9999 | | |