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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3) 300.1210d)4)A) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, 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	S9999		

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facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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

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

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician

5) A regular program to prevent and treat pressure sores, heat rashes or other skin

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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 evidence by:

Based on observation, interview, and record review the facility failed to monitor and treat a suspected deep tissue injury (SDTI) for 1 (R7) of 4 residents reviewed for pressure ulcers in the sample of 25. This failure resulted in R7's documented SDTI, reported as first being observed on 8/20/2024 to the right toe(s), having no skin monitoring or treatments implemented until 10/8/2024. At that time, gangrene was present requiring hospitalization with right second toe amputation on 10/19/2024. Subsequently R7 required additional amputation to the right lower extremity, above the right knee on 11/30/2024.

Findings include:

R7's "Admission Record" dated 1/29/25 documents R7's initial admission date to the facility as 5/9/17. Diagnoses listed on this same document include but are not limited to: Cerebral Infarction due to embolism of unspecified cerebral artery, Chronic obstructive pulmonary disease, type II Diabetes Mellitus, Morbid obesity, and Osteomyelitis.

R7's Braden Scale for Predicting Pressure Ulcer Risk dated 2/24/2021 documents she is a risk for

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pressure ulcers. No further updated Braden Scales were documented.

R7's Minimum Data Set (MDS), dated 8/5/2024 documents in section C, Cognitive Patterns that R7 has a Brief Interview for Mental Status (BIMS) score of 14, cognitively intact. This resident is at risk of developing pressure ulcers. No unhealed pressure ulcers.

R7's Physician's Order Sheet (POS) dated 8/2024 documents an order dated 12/20/2022 weekly skin checks on shower days Tuesdays and Fridays.

R7's Skin Observation Tool dated, 6/19/2024 documents R7 had an area on her left elbow. No other skin areas documented.

R7's Medical Record dated 6/20/2024 through 8/20/2024 no weekly skin assessments documented.

R7's Dialysis Foot Skin Assessment, dated 7/24/2024 documents no areas of concern on feet.

R7's Minimum Data Set (MDS), dated 8/5/2024 documents resident alert, no pressure ulcers, at risk of pressure ulcers.

R7's Nurse Practitioner Progress Note, dated 8/20/2024 documents skin is warm and dry, with no rashes, good skin turgor, no suspicious skin lesions.

R7's CNA (Certified Nurse Aide) Shower Sheet, dated 8/1/2024 through 8/19/2024 no skin areas of concern documented. 8/20/2024, 8/23/2024, 8/27/2024 and 8/30/2024 documents right

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foot/toe lateral and medial "bruising" and left heel "soft spot." A nurse signed each page of the shower sheets. Comments documented: sent to V3, ADON, wound nurse.

R7's Nurse Nursing Note, dated 8/21/2024 at 9:48 AM, documents dialysis nurse called to report area to resident left heel and right great toe. Wound nurse informed.

R7's Physician's Order Sheet (POS) dated 8/2024 documents left heel treatment start date 8/26/2024 left heel cleanse with normal saline or wound cleanser, paint with betadine, leave OTA (open to air) may cover if open and draining daily and PRN (when necessary) every day shift for wound care. No physician's order for treatment to resident's right toe.

R7's Care Plan dated 8/26/2024 documents R7 has potential impairment to skin integrity r/t (related to) fragile skin, edema and dry areas. Treatments ongoing as per MD (physician) orders. 8/26/2024 left heal DTI, wound company nurse practitioner treatment, treatment in place. Goal: resident will maintain or develop clean and intact skin by the review date. Interventions: float heels while in bed and encourage resident to elevate legs as often as possible, air mattress on bed, encourage side to side positioning with turn and reposition every 2 hours, follow facility protocols for treatment of injury, keep skin clean and dry, use lotion on dry skin. Offload heels by applying heel protectors when in bed. Educate to leave heel boots on, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.

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R7's Treatment Administration Record (TAR) dated 8/2024 staff documents 8/26/2024 through 8/31/2024 left heel treatment was administered. No documentation left heel treatments 8/21/2024 through 8/25/2024. No documentation of right toe wound being treatment.

R7's Dialysis Progress Note dated, 8/21/2024 at 10:50 AM documents pt (patient) c/o (complaint of) "feet hurt." Upon inspection large, darkened area noted to left heel/bottom of foot area and right great toe/top of right foot noted to have large red/purple area. Facility nursing home nurse, Former Administrator notified of areas. She states she will pass information along to restorative nurse.

R7's Wound - Weekly Observation Tool dated 8/21/2024, 8/28/2024, 9/4/2024, 9/10/2024, 9/17/2024, 9/24/2024, and 10/1/2024, documents dialysis reported an area to L (left) heel and R toe. L heel noted DTI (Deep Tissue Injury), order entered. The left heel first observation dated 8/21/2024 documents DTI measured 4.2 centimeters (CM) x 3.6 cm. No documentation of area on right toe documented.

R7's POS, dated 9/2024, documents an order dated 9/4/024 wound company to evaluate and treat left heel wound. No physician's order to treat the right toe.

R7's CNA Shower Sheet, dated 9/24/2024 documents "dressing" on (R7s) right foot. No nurse signature documented on shower sheet, or physicians order for a dressing documented.

R7's Wound - Weekly Observation Tool dated 10/8/2024 documents first observation SDTI on R (right) 1-2 toe crease, measured 0.4 cm x 2.8 cm

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100% slough with red peri wound tissue.

R7's TAR dated 10/9/2024 through 10/14/2024, documents a physician's order cleanse areas between right great toe and second toe with normal saline or wound cleanser. Apply betadine moistened gauze and cover with dry dressing every day shift for wound management.

R7's Nurse Progress Note, dated 10/15/2024 at 1:46 PM documents Weekly Wound Assessment-wound company nurse practitioner V16 seen resident this morning. L heel measures at 1.9 cm x 2.0 cm. Healing well. Continue with betadine paint and air dry. R 2nd and 3rd toe new area measures at 2.0 cm x 6.65 cm x 1.0 cm. Wound Nurse Practitioner explained to resident and family member regarding the need to be sent out to hospital for further workup with vascular regarding the new wound. Resident has abundance of purulent drainage and pain at the site. Applied moist betadine gauze bandage. Resident is a diabetic and currently receiving dialysis. Resident agreed to go to local hospital to be seen vascular. Will f/u (follow up) in 1 week.

R7's Hospital Discharge Paperwork dated 10/21/2024, documents, was hospitalized 10/15/2024 through 10/21/2024 documents hospitalization chief complaint worsening right toe wound. Resident stated wound has been present for a month has been present for 1 month but has been worsening and is painful. Right second toe dry gangrene and osteomyelitis. Acute on chronic right second toe wound x 1 month. Status post amputation of right 2nd toe on 10/19/2024. MRI showed Osteomyelitis (bone infection) involving first and second phalanges (toes) as well as base of first digital phalanax (toe.)

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R7's POS dated 10/2024, documents an order dated 10/15/2024 send to local hospital for evaluation and treatment related to right toe wound.

R7's POS dated 10/2024, documents an order dated 10/22/2024 right great inner toe apply betadine paint and let air dry daily and PRN every day shift for wound care. No treatments were documents as administered between 10/8/2024 and 10/15/2024. No physician's order to treat the resident right toe wound.

R7's TAR dated 10/2024, staff documented treatment per physician's orders was completed 10/26/2024 through 10/31/2024.

R7's Hospital Discharge paperwork dated 12/3/2024 documents she was admitted to the hospital with chief compliant status post right foot 2nd toe amputation due to wound was worse and had osteomyelitis in all toes on right foot at that time. An above the knee amputation was done on 11/30/2024 due to the worsening right foot wound.

On 1/30/2025 at 10:00 AM, R7 was observed lying in bed. She had an above the knee right leg amputation and her left foot was in a boot. R7 her feet hurt all the time and the pain started in 8/2024. R7 stated her right foot was a 6/10 on pain scale and 8/10 on her left foot. R7 stated at that time that if her right foot doesn't get any better that they are going to amputate it.

On 1/30/2025 at 10:25 AM V10, LPN, and V3, ADON, provided wound care to R7 with no issues. R7's left 2nd toe and 5th toe darkened. Skin between all toes is dark. Left heel scabbed over and dark. Right leg above the knee stump

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was dry with no open areas.

On 1/30/2024 at 10:20 AM V3, ADON stated each resident should have 2 shower sheets done per week and a licensed nurse should also be assessing each resident head to toe skin assessment and documentation should be in each resident's medical record. She stated she wasn't aware of R7's right toe wound on 8/20/2024 even though it's documented on the shower sheet that it was sent to her. She stated staff were documenting information in a phone communicate app at that time and she didn't see the message regarding the right toe. V3 confirmed she wasn't aware of any skin breakdown or issues with the resident's right toe until 10/8/2024, that was her first assessment of the resident's right toe, and she documented her assessment in the resident's medical record.

On 1/29/2025 at 8:45 AM V15, Dialysis Clinical Manager stated they check resident's feet at dialysis once a month. On 8/21/2024 the resident told dialysis staff that her feet hurt. Upon assessment of her feet, she had a large dark area noted to left heel and right great/top of right foot noted to have large red/purple area. The facility was notified of the skin areas of concern.

On 1/29/2025 at 12:30 PM, V2 Director of Nurses (DON) stated when residents are admitted to the facility one of the standing orders is for the resident to have a weekly skin assessment. V2 expects nurses to assess and document weekly skin assessments in the resident's medical record. When a new skin area is identified as a concern, she expects the nurse to assess the area and document what it looks like and measurements, she also expects the nurse to notify the physician and get a treatment in place

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immediately. When two areas of skin concern are identified at the same time the nurse should assess and document both areas of skin concern in the resident's medical record. V2 stated she knows the wound nurse practitioner was seeing the resident for her left heel and right toe but wasn't sure when she initially assessed the resident's wounds.

On 1/29/2025 at 12:38 PM V6, MDS/Care Plan Coordinator stated when a new skin concern is identified he expects the care plan to be updated immediately/within 24 hours. Residents are assessed quarterly for pressure ulcer risk assessment.

On 1/29/2025 at 12:45 PM V3, Assistant Director of Nurses (ADON) stated the wound nurse practitioner started assessing the resident's wound on her left heel on 9/10/2024 and right toe 10/15/2024. She was made aware of the area on the resident's right toe on 10/15/2024, V3 stated she was so focused on treating the resident's left heel that she wasn't aware of the area of concern on her right foot.

On 1/29/2025 at 12:55 PM V5, CNA Coordinator stated when staff document a "1" on resident's shower sheets it means bruising was observed and the nurse should go follow up on that documentation/finding.

On 1/29/2025 at 2:15 PM V13, CNA recalled documenting on R7 on 8/20/2024 and stated she documented bruising on her right foot, but it was of two "darkened areas" than bruising and her left heel was "soft." V13 stated she told the nurse (name unknown) about the areas of concern and the nurse signed her shower sheet to prove she was aware of the areas.

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On 1/30/2025 at 11:00 AM V16, Certified Wound Nurse Practitioner stated the resident has a lot of comorbidities including end stage renal failure and diabetes. V16 stated despite these comorbidities, when a wound is observed by staff, she expects staff to notify the nurse and the nurse should notify the primary care physician to obtain a wound treatment and to get the treatment in place as soon as possible. The nurse who initially assesses the new wound should the document color, size and presentation of the wound. The first time she assessed the resident's right foot was on 10/15/2024 and her 2nd toe was ischemic (reduced blood flow to specific tissue) and she notified the vascular physician at the local hospital and the resident was sent to the emergency room the same day. When she assessed the resident on 8/20/2024 she didn't do a full skin assessment, she only looks at concerns that the facility notifies her about it. She assessed the resident's left foot but wasn't notified of any concerns or issues regarding her right foot. V16 stated untreated wounds have the potential for serious harm or death due to infection. V16 stated she expected the facility to follow the pressure ulcer policy.

On 1/30/2025 at 11:38 AM, V17, Licensed Practical Nurse (LPN) stated she recalled the resident having skin breakdown on her feet in 8/2024 but she couldn't recall what her feet looked like at that time and she recalled messaging the wound nurse (V3) regarding the skin breakdown and she usually documents a nurse progress note when she assesses new skin breakdown but she didn't know if she documented it or not.

On 1/30/2025 at 1:08 PM, V3 ADON stated on

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10/8/2024 she can only assume the wound on (R7's) foot was worse and staff notified her of it and she assessed and classified it as a SDTI and then on 10/15/2024 when the wound nurse practitioner assessed it was a lot worse and that's why she was sent to the emergency room for further evaluation and treatment.

On 1/30/2025 at 1:35 PM, V17 LPN stated she knows for a fact that she reported (R7's) skin breakdown to V3 and this happens all the time that she and other staff including other nurses report to V3 concerns and issues and V3 always says "I didn't know about that, or no one told me about that."

On 1/30/2025 at 2:20 PM V13, CNA reviewed the shower sheet, dated 9/24/2024 she recalled the resident had a dressing on her right foot, but she didn't recall any details regarding the dressing.

On 1/30/2025 at 2:25 PM V18, Nurse Practitioner stated when nursing staff identify a new skin concern/wound she expects a licensed nurse to assess the area and to notify her or the resident's primary care physician the same day, typically the facility will phone or fax what the wound looks like and measurements and what the wound looks like and document if there is a treatment in place already. V18 expects the facility staff to follow the facility pressure ulcer policy. V18 stated staff should be assessing (R7's) feet because she has diabetes and anything on the foot with diabetes can continue to progress into a wound. Wounds and infections have the potential to lead to death if not treated appropriately and in a timely manner.

Review of the facility policy titled, "Pressure Injury Prevention and Management" dated 9/1/21

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documented, "The facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries." The same policy goes on to define avoidable as meaning, "that the resident developed a pressure ulcer/injury, and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate." "Policy Explanation and Compliance Guidelines" includes: "2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate ...3. c. Licensed nurses will conduct a full body skin assessment on all resident upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. D. Assessments of pressure injuries will be performed by a licensed nurse, and documented in the medical record ..."

(A)