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S 000	Initial Comments Complaint Investigations: 2542788/IL189212 2542792/IL189213 2542832/IL189285 2543321/IL190292	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3)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	S9999		

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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.

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

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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 Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to assess and identify a residents impaired skin integrity, failed to document weekly skin assessments, and failed to follow physician orders for pressure ulcer treatment for 3 of 4 residents (R7, R9, R14) reviewed for pressure ulcers in a sample of 29. This failure resulted in R7 developing pressure ulcer that upon identification was classified as an unstageable/stage 4, required significant debridement on multiple occasion, osteomyelitis and 7-day hospital stay.

Findings include:

1.R7's Face sheet documents R7 was admitted on 9/20/22 with a readmission date of 4/7/25 with diagnoses of Type 2 Diabetes, other symptoms and signs involving cognitive function and awareness, hydronephrosis, enterococcus, pulmonary embolism, sacrococcygeal disorders, not elsewhere classified, and presence of urogenital implants.

R7's Braden scale dated 9/20/2022 obtained during admission assessment, documented a score of 17 indicating R7 is at risk for developing pressure ulcer.

R7's Minimum Data Set (MDS) dated 9/26/22 documented that R7 is moderately cognitively

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impaired, no pressure ulcer/injury on admission. The MDS further documents R7 is at risk of developing a pressure ulcer with skin treatments recommended including a pressure reducing device for chair and for bed. R7 is at risk for developing a pressure injury and had no pressure ulcers present.

R7's MDS dated 1/20/25 documents R7 remains at risk for pressure injury but currently has no unhealed pressure wounds.

R7's MDS dated 3/6/25 documented that R7 is severely cognitively impaired, dependent on staff for all activities of daily living (ADL)'s. The MDS documents R7 is incontinent of bladder and bowel and is at risk for pressure ulcers and has one stage 4 pressure ulcers.

R7's MDS dated 3/28/25 documents R7 as moderately impaired cognition and dependent on staff for all ADL's, including turning and repositioning. The section regarding skin conditions documented yes to the question "resident has pressure ulcer/injury, a scar over bony prominence, or non-removable dressing, unhealed pressure ulcer."

R7's MDS dated 4/1/25 documents R7's cognition as (left blank), short-term memory "ok", no behaviors or inattention, disorganized thinking or altered level of consciousness. R7's MDS further documents R7 is dependent on staff for ADL's, including turning and repositioning.

R7's Social Service Note dated 3/6/25 documented R7 has clear speech, understands verbal content with severe impairment memory to recall after 5 minutes.

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R7's Care Plan dated 10/4/22 documented R7 has the potential for pressure injury development related occasional incontinence and decreased mobility. The goal is the resident will have intact skin, free of redness, blisters, or discoloration. Interventions include to apply skin barrier as needed, educate the resident and family on the causes of skin breakdown, educate the resident/family on the importance of change in position for prevention of pressure injuries, encourage appropriate hydration, encourage increased activity, if the resident refuses positioning, talk with the resident regarding the importance of positioning, maintain clean and dry skin, monitor nutritional status, and document/report changes in skin appearance and color. R7's care plan dated 12/11/2024 documents a potential for pressure injury development. The goal is that she will have intact skin and be free of open areas related to pressure. The interventions include air loss mattress with safety cover bolsters, air pressure redistribution, administer treatments as ordered, assist with position changes on rounds, barrier cream as directed, elevate/float heels while in bed, encourage to avoid lying or sitting on affected area, offer toileting assistance before and after meals, requires pressure relieving reduction devices on bed and chair.

R7's Shower sheet dated 2/3/25 documented dry flaky skin but no wounds.

R7's Shower sheet dated 2/9/25 documented no wounds.

There is no other documentation in R7's Clinical records of R7's skin assessment.

R7's progress notes dated 2/27/25 at 10:57 am

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documented a "Certified Nursing Assistant (CNA), came to nurse this morning, and notified nurse of a right-side coccyx wound/ulcer. Nurse went in to see the coccyx, cleaned it, and covered it. wound nurse notified and informed to look at it. change in condition assessment completed and doctor as well a family updated."

R7's progress notes dated 2/27/25 The Change in Condition (CIC) documented a skin wound. The skin status evaluation documented a pressure ulcer/injury. R7 was reported to have pain with the wound. Nursing observations, evaluation, and recommendations are open wound/ulcer on coccyx.

R7's Situation, Background, Assessment, Recommendation (SBAR) Summary for Providers dated 2/27/25 at 10:25 AM documents "Situation: The Change in Condition/s reported on this CIC Evaluation are/were Skin wound or ulcer.

R7's Wound Assessment Details dated 2/27/25 documents: site left ischial tuberosity, active, pressure, ulceration, facility acquired, unstageable, tissue: necrotic soft, adherent 100%, probable decline, size: 5.5 centimeters (cm) x 6.5cm x 0cm, area: 35.75cm, exudate: moderate serosanguineous, odor: yes, signs of infection present: unable to determine.

R7's Specialized Wound Management Physician Notes dated 3/3/25 document Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today ...Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary)

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hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements none, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Etiology- pressure, MDS 3.0 stage: 4, Duration: greater than one day, Wound size: 9.5 x 7 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 66.50 cm, Peri wound radius: odor, Exudate: heavy serous, Thick adherent devitalized necrotic tissue: 80%, Granulation tissue: 20%. Additional Wound detail: R7 states she has some type of cancer, dg(diagnosis) not found, not enough information in R7 chart; pending notes from PCP (primary care physician) or oncology; on exam today, no mass noticed on her back, sacrum, or legs. Expanded Evaluation Performed: The development of this wound and the context surrounding the development were considered in greater detail today. Relevant conditions including anemia, malnutrition, infection was considered and addressed through treatment changes or investigations. Thorough review of history performed, including speaking with Nursing staff for further information. Coordination of care and plan for this wound discussed with Nursing staff for further information. Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 30 days; Dakin's sol (solution) ¼ strength; gauze apply twice daily for 30 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 30 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; air cell wheelchair cushion; low air loss mattress. Indication for Procedure: Remove necrotic Tissue and Establish the

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margins of Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups were used to surgically excise 26.60cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 1.2cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 80% to 40%. Hemostasis was achieved and a lean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Deep swab technique performed on stage 4 pressure wound of the left ischium on 3/3/25. Procedure Today: surgical excisional debridement was performed today on this wound. Additional Recommendations related to performed expanded evaluation: lab name: white blood count (WBC), Deep wound culture, prealbumin.

R7's Skin/Wound Note dated 3/3/25 documents: "Resident was seen by V24, Wound Physician on 3/3/25 r/t (related to) her wound. R7 has a stage 4 to her left buttock with heavy serous drainage noted. It has 80% necrotic tissue and 20% gran tissue. Treatment of Dakin's moistened kerlix lightly packed in wound, abdominal (ABD) pad and secure with tape twice daily (BID) and as needed (PRN), glycated hemoglobin (HBA1C), prealbumin, complete blood count (CBC), hemoglobin (HGB) and White Blood Count (WBC) to be done for next visit. Interdisciplinary team (IDT), primary care physician (PCP), power of attorney (POA) and resident aware.
R7's Skin/Wound Note dated 3/3/25 documents: Tetracycline 500 milligrams (mg) 1 tab PO twice BID for 14 days and wound culture to be done.

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R7's Physician orders dated 3/3/25 documented treatment of Dakin's moistened kerlix lightly packed in wound, ABD pad and secure with tape BID and PRN, tetracycline 500mg BID and labs including a wound culture.

R7's Physician order dated 3/3/25 at 9:44 PM documented orders also to apply Santyl ointment to left buttock topically every day and evening shift for wound to left buttocks. Cleanse with normal saline apply Santyl ointment, calcium alginate and bordered gauze BID and PRN.

R7's March Treatment Administration Record (TAR) did not document R7 received treatments on 3/6/25(evening), 3/7/25 (morning), 3/8/25 (evening), 3/12/25 (morning) and 3/13/25 (evening). Treatment orders consisted of Apply Dakin's ¼ strength to left buttock topically every day and evening shift for wound. Cleanse left buttock with generic wound cleanser, pat dry, skin prep peri wound, allow to dry, pack wound lightly with Dakin's moistened kerlix, ABD pad and secure with tape BID and PRN.

R's Physician orders dated 3/3/25 documented an order for a wound culture.

R7's Wound Assessment Details dated 3/7/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 20%, necrotic soft, adherent 80%, has been debrided: no, probable decline, size: 9.5cm x 7.0cm x 0cm, area: 66.5cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no. Although R7's physician Order Sheet documents R7 was on antibiotic.

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R7's Specialized Wound Management Physician Notes dated 3/10/25 document Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today ...Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary) hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements none, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Focused Wound Exam (Site 1) Stage 4 Pressure wound of the left ischium full thickness: Etiology- pressure, MDS 3.0 stage: 4, Duration: greater than 8 days, Wound size: 9.5 x 6.5 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 62.70 cm, Exudate: heavy serous sanguinous, Thick adherent devitalized necrotic tissue: 70%, Granulation tissue: 30%. Additional Wound detail: Recommend increase protein intake with each meal and addition supplements three times a day, pending notes from PCP or oncology, importance of performing the dressing as per order discussed with rounding nurse. Expanded Evaluation Performed: The development of this wound and the context surrounding the development were considered in greater detail today. Patient not following reposition or offloading recommendations and counseling provided. Impaired nutritional status discussed with patient, family, nursing staff and/or dietician. Recommend consult/reconsult with dietician to review current nutritional status. Reviewed offloading surfaces and discussed surfaces care plan. Thorough

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review of history performed, including speaking with Nursing staff for further information. Coordination of care and plan for this wound discussed with Nursing staff for further information. Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 23 days; Dakin's sol (solution) ¼ strength; gauze apply twice daily for 23 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 23 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; pillow cushion; low air loss mattress. Site 1: Surgical Indication Debridement Procedure: Indication for procedure: Remove necrotic Tissue and Establish the margins of Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups were used to surgically excise 25.08cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 1.5cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 70% to 30%. Hemostasis was achieved and a clean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Investigations: Recommended and/or Reviewed: Deep wound culture pending on pressure wound of the ischium as of 3/10/25.

R7's Skin/Wound Note dated 3/10/25 documents: "Resident was seen by V24 on 3/10/25 r/t (related to) her wound. R7 has a stage 4 to her left buttock with heavy serous drainage noted. It has 70% necrotic tissue and 30% gran tissue. It has improved. Tx. Of Dakin's moistened kerlix lightly

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packed in wound, ABD pad and secure with tape IDT, PCP, and POA and resident aware. There is no documentation regarding the wound culture.

R7's Wound Assessment Details dated 3/13/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 30%, necrotic soft, adherent 70%, has been debrided: no, probable improvement, size: 9.5cm x 6.6cm x 0cm, area: 62.7cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no. R7's shower sheet dated 3/13/25 documents R7 did not have any wounds.

R7's Specialized Wound Management Physician Notes dated 3/17/25 documented Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today ...Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary) hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements none, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Focused Wound Exam (Site 1) Stage 4 Pressure wound of the left ischium full thickness: Etiology- pressure, MDS 3.0 stage: 4, Duration: greater than 15 days, Wound size: 9.5 x 6.3 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 59.85 cm, Exudate: heavy serous sanguinous, Thick adherent devitalized necrotic tissue: 50%,

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Granulation tissue: 50%. Additional Wound detail: Wound culture not performed yet, discussed with rounding nurse... Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 16 days; Dakin's sol (solution) ¼ strength; gauze apply twice daily for 16 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 16 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; air cell wheelchair cushion; low air loss mattress. Site 1: Surgical Indication Debridement Procedure: Indication for procedure: Remove necrotic Tissue and Establish the margins of Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, was used to surgically excise 17.96 cm of devitalized tissue and necrotic periosteum and bone were removed at a depth of 1.6cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 50% to 20%. Hemostasis was achieved and a clean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Investigations: Recommended and/or Reviewed: Deep wound culture pending on pressure wound of the ischium as of 3/17/25.

R7's progress note dated 3/17/25 at 9:31 pm documented resident was seen by V24 on 3/17/25 related to her wound. She has a stage 4 to her left buttock with heavy serous drainage noted. It has 50% necrotic tissue and 50% granulated tissue. It has improved. Treatment. of Dakin's moistened kerlix lightly packed in wound, ABD pad and secure with tape BID. There is no

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documentation for the wound culture.

R7's Wound Assessment Details dated 3/20/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 50%, necrotic soft, adherent 80%, has been debrided: no, probable improvement, size: 9.5cm x 6.3cm x 0cm, area: 59.85cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no.

R7's Dietary note dated 3/21/25 documents Diet: Low Concentrated Sweet (LCS), Regular, Thin; fortified ice cream four times per day (QID); liquid protein Intake: 50-100% Skin: Stage 4 wound on left ischial tuberosity Review: Resident is eating 50-100%of meals. Stage 4 wound noted, receiving liquid protein and fortified ice cream for wound as of 3/21/25.

R7's Specialized Wound Management Physician Notes dated 3/24/25 document Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today ...Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary) hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements multivitamins, protein, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Focused Wound Exam (Site 1) Stage 4 Pressure wound of the left ischium full thickness: Etiology- pressure, MDS

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3.0 stage: 4, Duration: greater than 22 days, Wound size: 9.5 x 8 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 76.00 cm, Peri wound radius: odor, Exudate: heavy serous sanguinous, Thick adherent devitalized necrotic tissue: 40%, Granulation tissue: 40%. Other viable tissues: 20% (bone) Additional Wound detail: Wound culture report never received. Performed another one today. Expanded Evaluation Performed: The progress of this wound and the context surrounding the progress were considered in greater detail today counseling offered to optimize wound healing and relevant conditions (or possible conditions) were addressed through management changes or investigation regarding conditions including anemia, noncompliance, malnutrition. Patient not following reposition or offloading recommendations and counseling provided. Impaired nutritional status discussed with patient, family, nursing staff and/or dietician. Recommend consult/reconsult with dietician to review current nutritional status. Medications affecting wound healing reviewed and considered. Reviewed offloading surfaces and discussed surfaces care plan. Coordination of care and plan for this wound discussed with Nursing staff for further information. Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 9 days; Dakin's sol (solution) ¼ strength; gauze apply twice daily for 9 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 9 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; air cell wheelchair cushion; low air loss mattress. Site 1: Surgical Indication Debridement Procedure: Indication for procedure: Remove necrotic Tissue and Establish the margins of

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Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups were used to surgically excise 7.60cm of devitalized tissue and necrotic periosteum and bone were removed at a depth of 1.6cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 40% to 30%. Hemostasis was achieved and a clean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Investigations: Recommended and/or Reviewed: Deep wound culture technique cancelled on stage 4 pressure wound of the left ischium on 3/24/25 (R7's record did not document the 3/3/25 orders result and thus cancelled on 3/24/25) Prealbumin recommended on 3/24/25. Deep swab technique performed on stage 4 pressure wound of the left ischium on 3/24/25.

R7's progress note dated 3/24/25 at 9:57 pm documented R7 was seen by V24 on 3/24/25 related to her wound. She has a stage 4 to her left buttock with heavy serous drainage noted. It has 40% necrotic tissue, 20% bone and 40% granulation tissue. It has exacerbated. R7 is noncompliant with off-loading wound and with wound care. Treatment of Dakin's moistened kerlix lightly packed in wound, ABD pad and secure with tape BID and PRN. Prealbumin and a deep swab performed and collected to be done for next visit.

R7's progress notes dated 3/26/25 documents R7 received intravenous infusion of Derma IV-DRIPT IV therapy infusion (500.9% normal saline with 5 gm Vitamin C, B Complex, biotin 10 mg, Arg 300

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mg, Om150mg, Lys 150mg, Cit 150 mg and zinc 10 mg.) due to Acute/Chronic Wounds It continues to document R7 received intravenous (IV) infusion d/t acute/chronic wounds. No adverse reaction noted upon post IV infusion. no bruising noted at IV site.

R7's Wound Assessment Details dated 3/29/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 50%, necrotic soft, adherent 50%, has been debrided: no, probable improvement, size: 9.5cm x 7.0cm x 0cm, area: 66.5cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no.

R7's shower sheet 3/31/25 documents shower given and no wounds present.

R7's Specialized Wound Management Physician Notes dated 3/31/25 document the patient visit had been rescheduled. R7 not in the facility currently.

R7's Specialized Wound Management Physician Notes dated 4/7/25 document the patient not seen due to wound related hospitalization since last visit.

R7's Wound Assessment Details dated 4/10/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25, unstageable, tissue: slough non adherent 10%, necrotic soft, adherent 90%, has been debrided: yes, probable decline, size: 10cm x 6.0cm x 0cm, area: 60.00cm, exudate: heavy purulent and malodorous , odor: yes, signs of infection present: yes. Is patient on antibiotic: no.

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R7's Laboratory Report dated 4/1/25 documents a wound culture with gram stain was collected on 3/25/25 with final report of heavy growth of proteus mirabilis and light growth of enterococcus faecalis. The Sensitivity report to medications does not indicate tetracycline, that was ordered for R7 on 3/3/25, as medication of choice sensitive to organisms.

R7's Progress notes dated 3/25/25 document R7 making loud moaning sound. Upon entering room, observe pt lying in bed with pillows surrounding her, lifted slightly off left hip. Call bell in reach. R7 stated "Why won't anyone help me?" Writer instructed that R7 has not used her call bell to alert any staff that she wanted or needed any help. R7 looked directly at call bell that was laying by her right hand on the bed and stated, "I'm so weak" Offered pain medication and R7 opened her mouth as in wanting pill dropped in. Asked R7 why she wasn't holding the pill cup and R7 stated "I'm so weak in my legs."

R7's Progress notes dated 3/26/25 documents R7 continues to hold on to call bell but instead is hollering out and becomes agitated that no one answers her. Writer has explained on each occasion that she should be using call bell because staff cannot always hear her yells.

R7's Progress note dated 3/26/25 documents R7 received IV infusion d/t acute/chronic wounds. No adverse reaction noted upon post IV infusion. no bruising noted at IV site.

R7's Follow up assessment post fall note dated 4/1/25 documents R7 is alert and orientated. R7 has sad worried facial expression. Pain scale 3 of 10, R7 has chronic pain though nights d/t hip

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wound. R7 has preexisting wound to hip.

R7's IDT note dated 4/1/25 documents Late entry: Root cause for fall on 4/1: R7 restless in bed due to pain. R7 sent to hospital per R7 and family request for pain control brief Interview for Mental Status (BIMS) 12. Care plan updated. Medical Doctor (MD) and POA aware.

R7's Nursing Note dated 4/1/25 documents "R7 grandson came to writer and reported that he overheard a female not talking very kind to his grandmother on the phone this morning. The female stated that was "she didn't know what to do help her anymore with her pain" R7 was voicing she just wanted to go to the hospital and the nurse responded "yes I'd be glad to send you to the hospital" in a sarcastic tone and not in a helpful way. R7 being transferred to hospital for chronic pain and wound management due to diagnosis cancer of the sacral area.

R7's Change in Condition dated 4/2/25 Reported: Altered Mental Status pain (uncontrolled). Nursing observations, evaluations and recommendations are: R7 noted to have AMS, attempting to climb out of bed and yelling for help. Stating she wanted to go to the hospital. This nurse manager went to room with nurse and CNA. Assured R7 that we would page MD. MD came verbal given to send R7 To Hospital. R7 was inconsolable and kept screaming at people despite attempts to help her. Primary Care Provider Feedback: Recommendations: Sent to Emergency Room (ER) for eval and tx (treatment).

R7's physician order set dated 4/1/25 documented to transfer R7 to the hospital for treatment and evaluation of uncontrolled pain

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S9999	Continued From page 19 related to pressure ulcer and sacral cancer. R7's Hospital History and Physical dated 4/1/25 documents R7 is an 85 year woman with significant PMH (past medical history) of T2DM (type 2 diabetes), HTN (hypertension), chronic UTIs (urinary tract infections), h/o (history of) outflow obstruction s/p(status post) right urethral stent right ovarian cysts, presacral spindle cell sarcoma arriving today from (facility) with concern for left hip pain, sacral ulcer and AMS. R7 is hemodynamically stable. Received cefepime and Flagyl in ER along with 1 liter (L) Normal Saline (NS) bolus due to elevated lactic acid level. Cat Scan (CT) of body significant for bilateral hydroureter nephrosis, presumable necrotizing fasciitis versus osteomyelitis. The patient was admitted for evaluation and management altered mental status (AMS) and hip pain/sacral pressure injury. Patient alert. Imaging suggestive of possible osteomyelitis and bilateral hydroureteronephrosis. Gen surg does not believe patient has necrotizing fasciitis. Continue abx(antibiotic) therapy. History of Present Illness: Labs significant for leukocytosis mostly recently 16.5, lactic acidosis, hyponatremia, hyperkalemia and procalcitonin 10.8. CT/C/A/A concerning for possible necrotizing fasciitis versus osteomyelitis of decubitus pressure wound. R7 received 1-time 50mcg of fentanyl for pain management. At bedside, R7 was alert and oriented x3. Speech difficult to comprehend due to anodontia/hypodontia. R7 endorses pain in her left buttock/Hip with inability to move her leg due to the pain. Moreover, she endorses fever, chills, shortness of breath and dysuria since this am. Physical Exam: Musculoskeletal: pain with passive range of motion left lower extremity, Integumentary: warm to touch, left sacral pressure injury.	S9999		

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R7's Computed tomography (CT) scan dated 4/1/25 documents a deep left decubitus ulcer to the left ischial tuberosity with cortical destruction within the bone compatible with osteomyelitis.

R7's Hospital Wound Nurse Consult dated 4/2/25 documents: Wound care: Pressure injury sacrum, stage 2, red, dark discoloration, red/rubor. Pressure Injury Left buttock, stage 3, red, white, necrotic tissue, eschar, necrotic tissue, slough, gaping, indurated, serous malodorous moderate drainage.

R7's hospital history and physical dated 4/1/25 documented R7 's computed tomography (CT) scan documented a deep left decubitus ulcer to the left ischial tuberosity with cortical destruction within the bone compatible with osteomyelitis.

R7's hospital records document a stay from 4/1/25-4/7/25.

R7's Progress note dated 4/7/25 documents arrived around 1445 on stretcher via ambulance from (local) hospital. Hospice nurse is here evaluating.

R7's Hospice Certification and Plan of Care dated 4/7/25 documents diagnosis in part of sepsis, pressure ulcer of left buttock, stage 4, osteomyelitis, Type 2 Diabetes Mellitus, full incontinence of feces, sacrococcygeal disorders not elsewhere classified and malignant neoplasm of connective and soft tissue.

R7's Nursing note dated 4/7/25 documents "R7 skin assessment completed. Hospital paperwork states there is a coccyx wound. There isn't." R7's clinical records do not document a wound on R7's coccyx rather on R7's left ischium.

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R7's Nursing note dated 4/8/25 documents "hospital discharge paperwork showed R7 had wound on coccyx. Hospice nurse and this nurse did skin check on R7 and nothing was noted on coccyx." R7's clinical records do not document a wound on R7's coccyx rather on R7's left ischium.

R7's April TAR documented to cleanse wound to left buttock with Dakin's; apply Santyl to necrotic tissue only followed by Dakin's wet to dry; cover with ABD pad and secure w/ Medi pore tape change daily & prn wound care as needed with a start date of 4/9/25 and an end date of 4/13/25. No documentation was present rom 4/10/25 - 4/13/25.

On 4/22/25 at 12:10 PM, V21(CNA) stated she noticed a white patch coming off R7's left buttocks when she was pulling up her incontinence briefs and notified the nurse on 2/27/25. V21 described this patch as a white gauze with tape on it. V21 stated R7 didn't always have a wound dressing and R7 was bigger and had lost weight so her skin on her buttock was different. V21 stated R7 did not have any previous open areas, no drainage. V21 stated R7 had a sacral mass but did not have any protrusion or open areas from it. V21 stated R7 was compliant with care.

On 4/22/25 at 11:45 AM, V30, Licensed Practical Nurse (LPN), stated V21, CNA notified her of R7's wound on 2/27/25. V30 stated that it was an open area that was bleeding on the right side of R7's buttocks. V30 stated she did not measure the wound at that time. V30 described R7's open area as more than a quarter size in diameter with bleeding, while holding up her right hand with V30's thumb and index finger making a circle

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larger approximately the size of a half dollar. V30 was again asked the location of R7's wound as R7 did not have any areas of skin impairment to her right buttock. V30 continued to state that R7's open areas were on her right buttock. V30 stated R7 was compliant with care. V2 was present for interview.

On 4/22/25 at 11:55 AM V2, state she went and asked V30 again about R7's open area on her buttock and stated V30 is sticking with what she said that the R7's open area on her buttock was on R7's right buttock even though there was never an open area on R7's right buttock and instead on the R7's left side.

On 4/21/25 at 1:15 PM, V20, LPN, stated that R7's wound was between her left buttocks and left ischial area but nearer the middle buttocks crack. V20 stated she did not have any wounds on her coccyx. V20 stated that she did not care for her regularly until the middle of March.

On 4/21/25 at 1:30 PM, V14, LPN, stated that R7 had one wound and it was located mostly toward the middle of her left buttocks. V14 stated that R7 did not usually refuse care.

On 4/22/25 at 10:05PM, V14 stated she cared for R7 between Thanksgiving and Christmas and R7 had a protrusion on her sacrum/coccyx but only saw it one time. V14 stated she thought R7 only had one area and it was on her sacrum/coccyx. V14 stated it was possible R7 had a pressure wound on her left ischium as there were several months where she hadn't taken care of her but was adamant that R7's wound was on her coccyx and there was only one area. V14 stated R7 did not have any area on her left buttock only her coccyx. Survey staff showed V 14 R7's 3/29/25

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pressure ulcer clinical documentation picture and V 14 stated I thought it was only one wound and it was on her coccyx.

On 4/22/25 at 10:51AM V48, Chief Nursing Officer of Specialized Wound Care Need reviewed R7's wound management notes and stated he was not seeing a sacral mass on R7, and the only treatment was R7's ischial tuberosity and R7 did not have a diagnosis of any sacral mass. V48 stated V34 notes document a skin assessment for R7 on 3/3/25 that document no mass, protrusion, or open area on R7's sacrum.

On 4/22/25 at 11:00AM, V28, CNA stated she was a little familiar with R7 and have seen R7's pressure wounds. V28 stated R7 only had one wound and it was on her left buttock and leg where it meets, and it was not covered. V28 stated she doesn't know anything about a sacral/coccyx mass. V28 stated CNAs are supposed to be documenting areas on shower sheets and reporting to nurses.

On 4/22/25 at 11:15AM, V29, Clinical Vice President (VP) Services, stated the facility has issues with skin assessment.

On 4/22/25 at 11:45AM, V2 stated she identified issues with staff assessment and made a change in staffing. V2 stated she moved the wound nurse (V18) to the floor and hired a new one as the old wound nurse was not doing a good job and wasn't documenting properly. V2 stated they had a lot of agency nurses in that didn't follow through with things and communication. V2 stated she has been the DON since February 5th and wasn't aware of any issues with R7 but would expect nurses to do treatment as ordered.

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On 4/22/25 at 12:38PM, V1 previous Administrator stated she was the Administrator when R7 was in the facility and wasn't aware of R7's left ischial tuberosity was compromised.

On 4/23/25 at 12:40 PM, V4, Regional nurse consultant, stated that was unable to find any wound results from a culture obtained on 3/3/25.

On 4/24/25 at 1:13PM, V2 stated she expects staff to identify, assess and document anatomical areas correctly. V2 stated she expects staff and the wound nurse to accurately identify and document if a resident was on antibiotic for wound infections and if they had debridement done.

On 4/30/25 at 10:40AM, V2 stated she expects staff to have basic knowledge of anatomical locations. V2, state she expects skin assessments upon admission and a second look the next day. V2 stated she wasn't sure on regular skin assessment or high-risk residents wasn't sure on facility policy but whatever policy is she expects staff to follow it. V2 stated she expects CNAs to document on shower sheets accurately and notify nurse of changes. V2 stated the nurse on duty signs off on shower sheets and agrees with what CNA skin assessment says. V2 stated she expects for nursing staff to look through orders from wound physician and to carry them out. V2 stated she expects staff to carry out the wound culture order from 3/3/25 but doesn't know what happened to it.

On 4/30/25 at 9:59am, V32 stated he would expect staff to know difference between two anatomical locations. V32 stated there can be human error for left and right can be easily confused but two locations V32 stated he would

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expect nurses to know the distinction, at least basic ones. V32 stated he would expect full skin assessment that includes every part of resident skin to identify anomalies and to look for any changes in nature of a resident's skin. V32 stated he was not familiar with R7 as he had only been in the facility a short time.

On 5/1/25 at 9:23AM, V32 stated the policy should be followed in doing weekly skin assessment for residents identified at risk on Braden per policy and can be found on the TAR. Review of TAR does not document weekly skin checks.

On 4/22/25 at 1:05 PM via telephone, V24 stated that R7 had a s very big and deep stage 4 pressure wound to her left ischium. V24 stated that when she first assessed R7's wound, it was huge, and it went straight to the bone. V24 stated that she obtained bone fragments and added that it was very deep, infected and to the bone. V24 stated that this left ischium pressure ulcer did not have anything to do with her cancer and was not eating from the inside out as the facility had suggested because there was no communication between these areas. V24 added if that was true there would be nothing there at all and wouldn't need debrided. V24 stated she had to debride R7's wound and it was down to the bone and that this was a pressure ulcer. V24 stated that R7 preferred to be up in the wheelchair, and this is how she got her pressure ulcer. V24 stated R7's pressure ulcer was on her left ischium and was infected, was necrotic, and smelled so bad. V24 started an antibiotic and performed a wound culture and waited for the culture to come back. V24 stated that she asked the facility for 3 weeks in a row and never received a result. By this time R7 had finished her previously ordered antibiotics

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and her pressure wound still was smelling, so she ordered another culture. V24 stated that she could not keep ordering antibiotics without a culture. V24 again stated this was a pressure ulcer and not a cancer wound. V24 stated that the facility described a sacral mass, and she requested notes on this but never received them. V24 stated upon her initial assessment of R7's pressure ulcer, she(V24) had never seen bumps on the buttocks or sacrum or nothing - no mass. Her skin was the normal skin color on her sacrum and intact. V24 stated that the two areas were two different anatomic areas and was two different locations. V24 acknowledged that her prealbumin was low but stated that is risk for a pressure wound, not healing. V24 stated this wound did not become a stage 4 pressure ulcer in one day. She stated that this was from R7 laying on that side or sitting in the wheelchair. V24 stated that every single wound is avoidable unless a resident is actively dying, and R7 was not actively dying so R7's wound was avoidable. V24 stated R7 is incontinent, so someone had to have seen her buttocks every day.

Skin Condition Assessment and Monitoring-Pressure and Non-Pressure originated on 11/2012 and last approved 4/2025, documented was reviewed, and it stated the purpose is to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions assuring interventions are implanted. Pressure and other ulcers will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. A skin condition assessment and pressure ulcer risk assessment will be completed at the time of admission/readmission. The pressure ulcer risk

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assessment will be updated quarterly and as necessary. Residents identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. If the resident receives a shower, it will be necessary to have the resident stand or be returned to bed to visualize the buttock area and groin. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing notes.

Pressure Ulcer Prevention originated on 11/2012 and last approved on 4/2025 documented the purpose is to prevent and treat pressure sores/pressure injury. The guidelines include to maintain clean/dry skin during daily hygiene measures. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated.

2. R14's face sheet documents his diagnoses to include diagnoses of cutaneous abscess of perineum, chronic kidney disease, diabetes, hyperlipidemia, hypertension, stable burst fracture of third lumbar vertebra, and pressure ulcer of left lower back, stage 4.

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R14's minimum data set (MDS) dated 4/2/25 documented that resident was originally admitted to the facility on 12/30/24 and recently readmitted on 3/27/25. This MDS also documented R14 s cognitively alert and oriented. R14 requires a walker for mobility and partial to substantial assistance with most activities of daily living (ADL's). R14 has one stage 4 pressure ulcer that was present upon admission to the facility.

R14's Care plan dated 3/27/25 documented focus problems that R14 is at nutritional risk relate to chronic kidney disease (CKD), has an ADL self-care performance deficit, is at a fall risk, at risk for skin impairment related to perineum abscess, and an actual skin impairment.

R14's Order dated 4/1/25 documented to cleanse left ischium with generic wound cleanser, skin prep peri wound, pat dry, lightly pack wound with 1/2" iodoform and cover with bordered gauze daily and as needed (PRN)

R14's physician's order dated 3/27/25 documented weekly skin assessment every Wednesday night shift.

R14's Progress note dated 4/1/25 documented R14 was seen by V24 (wound physician) on 3/31/25 related to his wounds. R14 has a wound to left ischium with moderate serosanguinous drainage noted. It has 70% slough and 30% granulation tissue. Treatment consists of iodoform lightly packed in wound and cover with bordered gauze daily and PRN.

On 4/3/25 at 11:55 AM, V17 performed wound care for R14. Wound was cleansed with wound cleanser, skin prep applied around the wound

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and 1/2-inch iodoform gauze inserted and covered with bordered gauze. R14 stated that his wound developed late in January. R14 stated that he feels his wound is improving. R14 reported decreased pain in the last 2 weeks. R14 usually receives daily dressing changes but sometimes not at all. R14 stated that about six days ago, there was a two-day period where the wound dressing was not changed for two days.

On 4/22/25 at 12:20 PM, V2 (DON) stated she was unaware that there were dates that R14 did not get wound care. V2 stated that staff should do treatments as ordered.

R14's April treatment administration record (TAR) with wound orders dated 4/2/25 documented no wound care on 4/4, 4/5, 4/6 with those selections left blank. The March TAR with wound orders dated 3/30/25 showed no documentation on 3/30 and 3/31.

3.R9's Care Plan, dated 10/23/2024, documents that R9 has the potential for alteration in skin condition r/t (related to) impaired mobility/incontinence. It continues Goal: The Resident will not develop a skin injury through next review. Interventions: Administer medications as ordered and monitor for adverse effects. Administer Treatments as ordered. Weekly skin checks. It also documents the resident has the potential for pressure injury development r/t (related to) immobility/incontinence. It continues Administer medications as ordered and monitor for adverse effects. Administer treatments as ordered.

R9"s Minimum Data Set, dated 1/13/2025, documents that R9 is cognitively intact, has 2 stage III pressure ulcers, and does not reject

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care.

R9's Medication/Treatment Administration Record (MAR/TAR), dated January 2025, documents Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply hydrocolloid 3 x (times) weekly, MWF (Monday, Wednesday, Friday), and PRN (as needed). every day shift every Mon, Wed, Fri for wound -Start Date 12/06/2024 0700 -D/C (discontinue) date 02/11/2025. There is no documentation on the TAR that R9's treatment was completed on 1/20, 1/27 and 1/29/2025.

R9's Progress Notes, dated 2/11/2025 10:31 PM, documents Skin/Wound Note Text: Resident was seen on 2/10/25 by V24, Wound Nurse, for her wounds. She has a stage 3 on her coccyx with moderate serosanguinous drainage noted. It has 100% gran (granulation) tissue. Tx (treatment). of collagen and bordered gauze dressing daily and PRN (as needed). Prealbumin to be done by next visit.

R9's Medication/ Treatment Administration Record, dated February 2025, documents Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply hydrocolloid 3x weekly, MWF, and PRN. every day shift every Mon, Wed, Fri for wound -Start Date 12/06/2024 0700 -D/C Date 02/11/2025 2146. There is no documentation on the MAR/TAR that this treatment was completed on 2/5/25.

R9's Medication/Treatment Administration Record, dated February 2025, cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply collagen and bordered gauze daily and PRN. every day shift for

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wound. -Start Date 02/12/2025 0700. There is no documentation R9 received this treatment on 2/19, 2/21, and 2/22/25.

R9's Progress Note, dated 2/19/2025 at 8:36 PM, documents Skin/Wound Note Text: Resident was seen on 2/17/25 by (V24), Wound Nurse, for her wounds. She has a stage 3 on her coccyx with moderate serosanguinous drainage noted. It has 100% necrotic tissue. Tx. (treatment) of Santyl, calcium alginate and bordered gauze dressing daily and PRN. IDT, PCP, and resident updated.

R9's Medication/Treatment Administration Record, dated February 2024, documents Santyl Ointment 250 UNIT/GM (Collagenase) Apply to coccyx topically everyday shift for wound Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply Santyl, calcium alginate and bordered gauze daily and PRN. -Start Date 02/18/2025 0700 -D/C Date 02/23/2025 1802. There was no documentation that R9 received this treatment on 2/19 and 2/22 and 2/23/25.

On 4/3/25 at 2:20PM, V4, (Regional Nurse Consultant), stated there have been changes since the change of ownership. V4 stated staffing is a problem, they have gotten 2-3 admissions, and management doesn't come out to help. V4 stated the wounds have gone downhill. V4 stated they have a full-time wound nurse, but she only does rounds with the wound doctor once a week, she doesn't do the wound care any other time, not even the pressure ulcers, which would help. V4 stated that with short staff this causes things to be missed.

On 4/9/2025 at 4:05 PM V1, Administrator, stated that she would expect the nurses to sign off the

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medication/treatment record when the treatment is completed.

The facility's Medication Administration policy, dated 5/2025, documents that Policy I. LEVEL OF RESPONSIBILITY: Licensed nurse (RN, LPN) may: a) prepare, b) administer, and c) record the administration of medications (prescription ointments are considered medicines) Medications shall always be prepared, administered, and recorded by the same licensed nurse or CMA. Documentation of medication administration is recorded on the Medication Administration Record (MAR.) or Treatment Record and includes the date, time, time, and initials of the licensed nurse or CMA who administered the medication. II. ADMINISTRATION OF MEDICATIONS: Medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route, and right time.

The facility's Pressure Ulcer Prevention policy, dated 5/2025, documents that the purpose is to prevent and treat pressure sores/pressure injury.

(A)