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S 000	Initial Comments Annual Licensure Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2)3) 300.1210d)5 300.1220b)3 300.2010a)1)2) 300.2010b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999		

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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 develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

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

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3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.2010 Director of Food Services

a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week.

1) This person shall be either a dietitian or a dietetic service supervisor.

2) The person responsible for the food service may assume some cooking duties but only if these duties do not interfere with the responsibilities of management and supervision.

b) If the person responsible for food service is not a dietitian, the person shall have frequent and regularly scheduled consultation from a dietitian. Consultation, given in the facility, shall include training, as needed, in areas such as menu planning and review, food preparation, food storage, food service, safety, food sanitation, and use of food equipment. Clinical management of therapeutic diets shall also be included in

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consulting, covering areas such as tube feeding; nutritional status and requirements of residents, including weight, height, hematologic and biochemical assessments; physical limitations; adaptive eating equipment; and clinical observations of nutrition, nutritional intake, resident's eating habits and preferences, and dietary restrictions.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements were NOT MET as evidenced by:

Based on observation, interview, and record review the facility failed to initiate a wound care plan, failed to update a care plan with interventions for two pressure ulcers, and failed to prevent the worsening of pressure ulcers by not providing pressure relief and not providing adequate nutrition to support wound healing, facility failed to provide a physician ordered diet and failed to report new facility acquired pressure ulcers and significant weight loss to the Registered Dietician (RD) for one (R22) resident out of two residents reviewed for pressure ulcers in a sample of 37 residents. This Failure resulted in R22's pressure ulcer worsening from stage II to Stage IV and developing 2 new pressure ulcers and (R22) losing 15% of body weight in 9 days.

Findings include:

R22's undated Face Sheet documents R22 admitted to the facility on 4/25/25. This same face sheet documents medical diagnoses of

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Encephalopathy, Cerebral Infarction, Cardiomyopathy, Diabetes Mellitus Type 2, Left Femur Fracture, Anemia and Myocardial Infarction Type 2.

R22's Minimum Data Set (MDS) dated 4/29/25 documents R22 as severely cognitively impaired. This same MDS documents R22 requires assistance with eating and is dependent on staff for toileting, bathing, dressing, bed mobility and personal hygiene.

R22's Baseline Care plan dated 4/26/25 documents R22 admitted with a Coccyx Pressure Ulcer. This same care plan was not updated with R22's facility acquired Left and Right Heel Pressure Ulcers nor any new interventions for R22's worsening Coccyx pressure ulcer.

R22's Physician Order Sheet (POS) dated May 2025 documents a physician order starting:
--4/28/25-5/18/25 to apply skin barrier to bilateral heels.
--5/13/25 with no end date for wound care: Cleanse coccyx with wound cleaner, apply an absorbent bordered dressing every 3 days and as needed every day shift every 3 day(s) for wound healing/preventative AND as needed.
--5/18/25 with no end date to apply Betadine to R22's Left Heel twice daily for a pressure sore.
--5/20/25 with no end dated to apply Betadine to R22's Right Heel daily.

R22's Nurse Progress Note dated 5/12/25 at 1:00 PM documents R22 was provided an air mattress. R22's Nurse Progress Notes prior to 5/12/25 do not include any documentation of R22 being provided an air mattress.

R22's EMR documents R22's Superior Coccyx

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Wound Assessment:

--initiated and completed 4/26/25 documents R22's Superior Coccyx Pressure Ulcer as a Stage II noted on 4/25/25 measuring 2.2 cm long by 1.0 cm wide by 0.1 cm deep with serosanguinous drainage and no odor.

--initiated 5/3/25 and completed 5/12/25 documents R22's Superior Coccyx Stage II Pressure Ulcer measures 2.2 cm long by 1.0 cm wide by 0.1 cm deep with serous drainage as unchanged.

--initiated and completed 5/18/25 documents R22's Superior Coccyx Stage II Pressure Ulcer merged with R22's Inferior Coccyx Stage II Pressure Ulcer Creating a labeling change now referred to as R22's 'Coccyx' Stage II Pressure Ulcer. R22's EMR did not include any documentation of R22's Inferior Coccyx Stage II Pressure Ulcer.

R22's EMR documents R22's Coccyx Wound Assessment:

--initiated and completed on 4/26/25 documents R22's Coccyx Stage II Pressure Ulcer measures 2.0 cm long by 1.2 cm wide with no measurable depth has serous drainage.

--initiated and completed on 5/18/25 documents R22's Coccyx Stage II Pressure Ulcer measures 3.4 cm long by 1.7 cm wide by 0.1 cm deep with serous drainage. This assessment documents R22's Coccyx pressure ulcer has deteriorated.

R22's Electronic Medical Record (EMR) documents R22's Left Heel Wound Assessment:

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--initiated 5/5/25, competed 5/18/25 documents R22 acquired a new Left Heel SDTI (Suspected Deep Tissue Injury) on 5/4/25 measuring 2.5 centimeters (cm) long by 2.1 cm wide with immeasurable depth.

--initiated and completed 5/18/25 documents R22's facility acquired Left Heel SDTI measures 3.5 cm long by 2.6 cm wide by immeasurable depth. This same assessment documents R22's Left Heel as worsening.

R22's EMR documents R22's Right Heel Wound Assessment:

--initiated 5/13/25 and completed 5/20/25 documents a new facility acquired Right Heel Suspected Deep Tissue Injury (SDTI) as measuring 3.5 cm long by 2.0 cm wide with no measurable depth.

--initiated and completed on 5/20/25 documents R22's Right Heel SDTI measures 3.5 cm long by 2.6 cm wide with no measurable depth and deteriorating.

On 5/18/25 from 8:45 AM-11:15 AM R22 was laying on her back in her bed. No staff offered to reposition R22 during that timeframe. R22 was not wearing heel protectors. R22's bilateral heels were resting directly on the bed.

On 5/19/25 at 10:25 AM V10 Licensed Practical Nurse (LPN) and V21 Certified Nurse Aide (CNA) completed R22's Coccyx and Left Heel wound care treatment. R22 was laying on her back as staff entered her room. V10 LPN and V21 CNA assisted R22 to her side to visualize R22's Coccyx wound. R22's Coccyx pressure ulcer was covered with a blood soaked absorbent dressing

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that was dripping blood onto R22's incontinence pad due to over saturation. R22's Coccyx pressure ulcer was described by V10 LPN as open, the size of a baseball with bone structure and muscle visible, 30% yellow slough on upper edges, 10% dark black necrotic tissue on bottom edge of wound, faint foul odor and dark red periwound. V10 LPN stated R22's Coccyx pressure ulcer would be considered a Stage IV due to being able to visualize R22's Coccyx bone. V10 LPN described R22's Left Heel SDTI as large, purple, fluid filled and closed pressure ulcer the size of a small orange. R22's Left Heel SDTI was located on the bottom and outer side of R22's Left Heel. V10 LPN lifted R22's Right Heel to show what V10 LPN described as purple, flush with the skin, golf ball sized outer area with a darker nickel sized center that appeared as if it had opened and then dried up. V10 LPN stated R22's Right Heel felt 'scabby' on the bottom and would be considered an SDTI. R22's Right Heel SDTI was located on the bottom and inner side of R22's Right Heel. R22 yelled out multiple times 'Ow!' and 'That hurts so bad!' and 'I hurt so bad' throughout wound care. R22 showed facial grimacing during wound care.

On 5/19/25 at 10:45 AM V10 Licensed Practical Nurse (LPN) stated R22 admitted with her Coccyx wound. V10 LPN stated the facility has caused R22's Left and Right Heel SDTI's. V10 LPN stated that size of wound does not happen overnight. V10 LPN stated it takes a few days for that size of pressure ulcer to appear. V10 LPN stated the bottom of R22's Right Heel looked like it had been filled with fluid, burst and then dried back up. V10 stated from the look of both heels it was apparent that R22 had laid on her Left side for too long causing her heels to be pushed into the mattress. V10 LPN stated there is no other

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way for R22's heels to have matching SDTI's in those areas.

On 5/21/25 at 9:05 AM V17 facility Registered Nurse (RN)/Hospice RN stated V17 is the Hospice RN for R22 and has seen R22 multiple times. V17 stated R22 admitted to the facility with a 'minor' Coccyx pressure ulcer that has worsened under the care of the facility. V17 stated R22 has also obtained facility acquired SDTI's to her bilateral heels since V17's admission to the facility. V17 stated V17 and V10 Licensed Practical Nurse (LPN) both assessed R22's Right Heel SDTI on 5/13/25. V17 stated at that time R22's Right Heel had a 'typical' SDTI fluid filled pocket on her Right bottom and inner side of her Right heel. V17 stated she recommended R22 to have Betadine to both heels that day (5/13/25).

On 5/21/25 at 9:10 AM V18 Hospice Registered Nurse (RN)/Case Manager stated Hospice does not cover wound dressings for healing but only for comfort. V18 stated since R22's payer source is Medicaid R22 would be eligible to have wound supplies paid for by the Medicaid program. V18 stated R22 could have been receiving more aggressive wound treatment including seeing V22 traveling wound Nurse Practitioner (NP) since her admission. V18 stated she is not sure why the facility did not provide more aggressive wound care with a deteriorating wound and two new facility acquired wounds but that would have reduced the chances of R22's deteriorating and/or developing.

On 5/18/25 at 12:40 PM V7 (R22's) Power of Attorney (POA) stated R22 has been losing weight and has been very ill. V7 stated "I know (R22) is on hospice but I don't even know why.

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(R22) is wasting away. We (V7, R22) have been married 50 years and we take care of each other. (R22) is losing weight because they (staff) don't feed her. I don't know why they don't feed her real food. We all know what is going to happen but that doesn't mean we should starve (R22)".

On 5/19/25 at 10:25 AM V10 Licensed Practical Nurse (LPN) and V21 Certified Nurse Aide (CNA) completed R22's coccyx dressing change. V21 CNA assisted R22 to her side for the dressing change to be completed. After completion of R22's Coccyx dressing change, V21's indentation of her hand was visible on R22's Left outer buttock. V10 LPN stated R22 was very dehydrated from not eating any foods.

On 5/19/25 at 12:30 PM V7 (R22's) Power of Attorney (POA) was standing at R22's bedside assisting R22 in eating. R22's facility tray contained two small glasses of thickened juice, one small container of yogurt and small prepackaged containers of one pudding, one applesauce and one yogurt. R22 stated she would love to eat turkey and potatoes. V7 (R22's) POA stated R22's favorite food is potatoes.

On 5/20/25 at 1:20 PM V23 Certified Nurse Aide (CNA) stated V23 re-weighed R22 on 5/20/25 with a result of 94.4 pounds (LBS). V23 CNA stated "It might help if we (facility) would have fed (R22). I don't know why (R22) had only been getting yogurt, applesauce and pudding. (R22) has really lost a lot of weight."

R22's Hospital Discharge orders dated 4/25/25 document R22 needs very persistent oral intake encouragement.

R22's Electronic Medical Record (EMR)

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documents R22 weighed 114.6 pounds (lbs) on 5/1/25, 114.6 lbs on 5/2/25, 114.1 lbs on 5/3/25, 113.0 lbs on 5/4/25, 111.0 lbs on 5/18/25 and 94.4 lbs on 5/20/25.

On 5/21/25 at 10:00 AM V15 Registered Dietician (RD) stated R22 was not served a sufficient amount of protein and calories to support wound healing. V15 stated she would have recommended protein supplements for R22 but V2 Director of Nursing (DON) instructed V15 to not do that due to R22 would not tolerate them. V15 RD stated she was not informed that R22 had a Left and Right SDTI that were facility acquired.

On 5/21/25 at 12:00 PM V2 Director of Nursing (DON) stated R22 was admitted to the facility on 4/25/25 and placed on Hospice on 5/10/25 due to Senile Degeneration of the Brain. V2 DON stated R22 originally admitted as a short term resident for rehabilitation after her surgical repair of her Left Femur fracture. V2 DON stated R22's Coccyx wound worsened at the facility from a healthy Stage II to a Stage IV with necrotic tissue and a foul odor. V2 DON stated R22 did acquire two new pressure ulcers on each Heel while at the facility. V2 DON stated the facility did not transcribe R22's orders and should have the appropriate documentation on R22's Electronic Medical Record (EMR). V2 DON stated R22's dressings were being monitored by Hospice and the dressing supplies were ordered by Hospice. V2 DON stated R22's payment source was never brought into the wound discussion and should have been if R22 could have been receiving more aggressive wound care. V2 DON stated that could have helped R22 from forming new pressure ulcers and could have prevented R22's Coccyx pressure ulcer from worsening. V2 DON

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stated there is very poor communication from Hospice to the facility staff and from the facility staff to the nursing management. V2 DON stated V2 was told on 5/17/25 that R22 had a new Left Heel pressure ulcer and on 5/19/25 of her Right Heel pressure ulcer.

The facility policy titled Physician Orders dated February 14, 2023 documents the physician order sheet will be maintained with current orders as new orders are received.

The facility policy titled Skin Prevention Assessment and Treatment dated May 2, 2022 documents residents with a Braden Scale score of 12 or less should be considered to be "at high risk" for pressure ulcer development. Residents identified as high risk should be discussed and addressed in the Resident's care plan to assure appropriate interventions to manage the risk are implemented. These risk factors include, but are not limited to exposure of skin to urinary or fecal incontinence, impaired or decreased mobility and functional ability, under nutrition, malnutrition, and hydration deficits, comorbid conditions (e.g., diabetes mellitus, end-stage renal disease, thyroid disease), drugs that may affect ulcer healing (e.g., steroids), Impaired diffuse or localized blood flow (e.g., generalized Atherosclerosis, lower-extremity arterial insufficiency), increase in friction or shear, moderate to severe cognitive impairment. Resident refusal of some aspects of care and treatment of any skin impairments, including pressure ulcers, non-pressure ulcer wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse, or designee, in the Medical Record.
A Violation