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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a) 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: 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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 300.3240 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 REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observation, interview, and record the facility failed to failed to conduct comprehensive assessment and evaluate the root cause for the development of the facility acquired pressure ulcers for R 1 and R 15. Failed to evaluate and implement an individualized repositioning plan for R 1 and R 15 and to revise plan of care to promote healing and prevention of of development of additional pressure injury in the facility. The facility failed to implement interventions to prevent the worsening of pressure injuries to the	S9999		

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left elbow and left buttock areas and failed to follow the doctor's orders for the treatment of the left elbow pressure injury related to off-loading the area for R13. The facility also failed to develop and implement individualized interventions including turning and repositioning, use of positioning devices as a measure to prevent the development of Deep Tissue Pressure Injury for R20.
These failure resulted in: (1) R 1 acquiring a left ischial Stage IV pressure injury, multiple Stage 2 pressure injuries on the sacrum and a left and right buttock ' s Deep Tissue Pressure Injury that the facility was not aware. (2) R 15 acquired multiple areas of Stage 4 (Sacral, right and left ischium and left hip). (3) R13's pressure injuries worsened to her elbow and left buttocks area. (4) R20 acquired two Deep Tissue Pressure Injuries (DPTI) to her left heel and one DPTI to her right heel.
This applies to 4 of 4 residents (R 1, R 15, R13, R20) reviewed in the sample of 30 residents for pressure injuries.
The findings include:
1. R 1 admission record shows R 1 was admitted to the facility with diagnoses to include severe brain injury, neurogenic bladder, hypertension, and anemia.
On December 13, 2016 at 10:35 AM, R 1 was noted lying flat in bed, non-verbal, with oxygen via nasal cannula and a gastrostomy tube feeding.
On December 14, 2016 at 9:25 AM, R 1 was noted in bed lying on his back, at 10:40 AM and at 11:25 AM R 1 remained in the same position.
On December 15, 2016 at 12:20 PM, E 37 (Certified Nursing Assistant) stated, " I had him (R 1) yesterday (December 14, 2016), I worked from 6 AM through 2:00 PM, I usually check him (R 1) around 7:30 AM, empty his urinary bag and at 8:30 AM, I clean him up. When I cleaned him

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up, I saw a little bleeding on his buttocks, I told the Nurse, she said she would tell the wound team. I went back and check on him around 12:00 PM. "

On December 14, 2016 at 11:40 AM, during treatment observation with E 6 (Treatment Nurse) and E 36 (Certified Nursing Assistant), E 6 identified a Stage IV pressure injury on R 1 ' s left ischium, measured at 1.5 cm X 0.5 cm X 1.0 cm. E 6 explained, " It was staged at IV because I can feel the bone. " R 1 ' s most current weekly pressure ulcer progress report presented by E 5 (Wound Nurse Director) showed that on December 8, 2016 this pressure injury (Left ischium) was measured at 1.0 cm X 0.7 cm X 0.4 cm.

During this observation, a dried blood approximately 3.0 cm X 6.0 cm was noted on R 1 ' s sacral area. E 6 cleansed the sacral area and identified multiple stage II ' s. R 1 was also noted with two areas of Deep Tissue Pressure Injury described by E 6 as deep dark purple in color on the right buttocks measuring 5.0 cm X 3.5 cm and on the left buttocks measuring 3.0 cm X 3.0 cm.

On December 15, 2016 at 10:50 AM, E 5 (Wound Nurse Director) explained that the facility has no comprehensive assessment to analyze and identify the root cause of R 1 ' s development of pressure injury on the left ischium. E 5 explained, " R 1 is totally dependent on staff with activities of daily living and repositioning. " E 5 reviewed and presented R 1 ' s wound care plan and explained, " This wound was initially identified on January 1, 2016 and it was a Stage IV already. "

R 1 ' s Stage IV (pressure injury) care plan showed the following interventions:

Assess for pain prior to dressing changes;

Wound MD to evaluate; Low air loss mattress; monitor for sign and symptoms of infection;

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prostat 30 cc; roho cushion while on wheelchair; treatment done per order and wound documentation in place and updated weekly as needed.
E 5 also explained that the facility uses the Braden scale, the weekly pressure ulcer progress report; the doctor wound progress notes and the care plan to document the progression of wounds. R 1 ' s progress notes showed that the wound doctor last saw R 1 on October 3, 2016.
On December 15, 2016 at 11:50 AM via phone, Z 5 (Nurse Practitioner) stated, " I was informed this morning that they found new areas on his (R 1) buttocks. They should be repositioning him at least every two hours to prevent pressure and to promote healing. As a rule it should be every two hours but again it depends on the skin condition of the patient, some might need more frequent turning and positioning. "

2. On December 13, 2016 at 10:20 AM, R 15 was in bed lying on his back sleeping. R 1 was noted with a splint on the left arm and with an indwelling urinary catheter. On December 14, 2016 at 9:35 AM, R 15 was observed lying flat in bed, E 42 (Nurse) described, " He had a stroke with left side weakness, feeder and he stays in bed most of the time. He has a big wound on his sacrum. "
R 15 ' s admission record shows R 15 was admitted at the facility on July 26, 2016 with diagnoses to include neuromuscular dysfunction, cerebralvascular accident, hemiplegia, and aphasia. R15 ' s wound report/ documentation dated December 9, 2016 showed R 15 has a Stage IV on the right ischium (0.5 cm X 0.8 cm X 0.5 cm) and left ischium (0.5 cm X 0.7 cm X 0.3 cm) and a Stage III on the sacrum (8.0 cm X 7.0 cm X 1.0 cm).
On December 14, 2016 at 10:10 AM, during treatment observation with E 6 and E 5, both E 6

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and E 5 stated, " All of R 15 ' s pressure ulcers are acquired from the facility. " E6 identified the following:
Sacral Stage IV measuring 9.5 cm X 9.0 cm X 1.2 with undermining at 12 o ' clock 1.2 cm, 1.7 cm at 1 o ' clock, 1.2 cm at 2 o ' clock, 2.5 cm at 9 through 11 o ' clock, 1.7 cm at 11 through 12 o ' clock and 1.5 cm at 7 o ' clock.
Left ischium Stage IV measured at 1.0 cm X 0.5 cm X 0.7 cm
Right ischium Stage IV measured at 0.5 cm X 0.5 cm X 0.5 cm " I can feel the bone. "
Left hip Stage III, E 6 described, " This was Stage III but now there is a thick eschar (75 %) covering the wound so it would be Unstageable. " This pressure injury was measured at 1.5 cm X 1.3 cm.
R 15 ' s pressure injury on the sacrum and left ischium increased in size. There was no wound progress report/ documentation found on R 15 ' s wound on the left hip.
E 5 explained, there was no comprehensive assessment to evaluate R 15 ' s root cause for the development of multiple areas of pressure injury.
R 15 ' s skin alteration care plan was not individualized based on R 15 ' s needs.

3. On December 13, 2016 at 10:15 AM, R13 sat in her wheelchair in the dining area. E38 (Registered Nurse-RN/Care Plan Coordinator) said R13 has a pressure wound to the left elbow and left buttock areas. There was no protective pad seen under the left elbow. The left elbow was pressed against the wheelchair arm rest. E38 said the elbow wound came from pressure when the resident pushes her elbow against the bed.
R13's POS (Physician Order Sheet) dated November 9, 2016 showed an order of "get elbow pad for left elbow."

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S9999	Continued From page 6 On December 14, 2016 at 12:11 PM, E6 (Registered Nurse-RN Treatment Nurse) started the wound treatment to R13's left elbow pressure injury. There was no elbow pad seen to protect the area. E6 said there was an order for an elbow pad but acknowledged that there was no elbow pad applied to protect the left elbow. E6 described the left elbow area as a stage IV pressure injury, reddish around the wound bed with the tendons exposed. E6 removed the dressing to the left buttock pressure injury. E6 described the left buttock area as an unstageable wound covered with 100% eschar. E6 measured the pressure wound to the left elbow area as 4.5 cm (centimeter) in length, 5 cm in width and 0.5 cm in depth. There was undermining at 4 o'clock and 9 o'clock. The undermining at 4 o'clock to 8 o'clock was measured at 1.5 cm and the 9 o'clock undermining was measured at 1.0 cm. E6 measured the pressure wound to the left buttock area as 7.5 cm in length, 7.0 cm in width and with no depth. On December 15, 2016 at 12:20 PM, E5 (LPN-Licensed Practical Nurse/ Treatment Nurse) said the facility's Braden Scale Assessment (used to assess risk for pressure injury) is done upon Admission and for the succeeding 4 weeks and then Quarterly. R13's Braden Scale document shows R13 was assessed as High Risk for Pressure Sore (score of 12) on August 3, 2016, October 29, 2016 and November 24, 2016. The facility's undated Protocols for "At Risk" Residents document shows, "Interventions are directed toward minimizing and/or eliminating the effects of the causal/contributing factors: pressure, moisture, friction/sheer and nutrition." E5 stated there should be off-loading for any pressure.	S9999		

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E5 (LPN/Treatment Nurse) explained R13's pressure injuries were community-acquired when R13 returned from the hospital on August 4, 2016.
R13's Shower/Skin Observation Report dated August 4, 2016 showed "Left elbow healing wound 3.5 x 1.5 centimeters. "The same document showed, "Left buttock redness, Blanchable"
There were no documentation presented regarding the left elbow and left buttock pressure injuries from the time it was first documented on August 4, 2016 until November 7, 2016.
E5 stated treatments were done by the wound treatment staff and when there was no improvement seen, the in-house wound doctor was reached out with new orders.
There was no documentation, measurements presented regarding the pressure injuries from the time it was first noticed on August 4, 2016 until a weekly pressure ulcer progress report was done in November 7, 2016.
The facility's Weekly Pressure Ulcer Progress Report showed only the measurements and status of the left elbow pressure injury on November 7, 2016-stage IV, 3.3 x 3.1 cm; November 21, 2016-stage IV, 3.5 x 3.5 cm; November 28, 2016-stage IV, 3.0 x 3.0 cm; December 5, 2016-stage IV, 5.0 x 3.0 cm and December 12, 2016- stage IV, 5.4 x 3.0 cm.
There was no measurement and documentation presented regarding the pressure injury on the left buttock.
R13's care plan with the initiated date of November 7, 2016 did not show any specific interventions for her left buttock pressure injury. The same care plan talked only about the left elbow with no specific interventions. It was also written on the same care plan that R13 was placed under hospice care on November 11,

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2016.
E5 said there were no other documentation of the status of the pressure injury to the left elbow and left buttock other than the ones the wound doctor wrote starting after the referral was done on November 9, 2016.
R13's Progress Note from the wound doctor dated November 9, 2016 showed, "Left buttock severe excoriation,10 cm." The same document showed, "left elbow pressure area measured at 4 cm x 3 cm x fibrin filled/slough filled bed."
R13's Progress Note from the wound doctor dated December 5, 2016 showed, "Left ischium area 8 cm x 7 cm with thick eschar." The same document showed, "left elbow-area exposed bone at 3 cm x 3 cm."

4. On December 15, 2016 at 11:25 AM E18 (Nurse) went to R20's room to administer medication via gastrostomy tube. R20 was lying in her bed in supine position, her legs were crossed left over right, her heels were pressing against the mattress and she had no foot wear or socks. R20 was also incontinent of bowel and bladder. E18 summoned E17 (Certified Nurse Aide - CNA) to provide incontinence care.

When E17 turned R20 to her side lying position, it was observed that R20's heels had deep tissue pressure injury (DTPI) with dark black discoloration and did not blanche even after relieving pressure for more than 15 minutes. R20's left medial heel skin was mottled. R20's left and right medial buttocks had dark black discoloration which did not blanche even after relieving pressure for 15 minutes. E18 and E19 (Nursing Care Plan Coordinator / Supervisor) verified R20's skin condition and DTPI and they summoned E5 (Pressure Injury Treatment Nurse) to evaluate R20's skin condition and DTPI.

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E6 (another pressure sore treatment nurse) presented R20's DTPI report dated December 15, 2016 which read as under:
Left lateral heel DTPI 1.0 cm (centimeter) x 3.0 cm dark brown area nonblanchable.
Left medial heel DTPI 2.0 cm x 2.5 cm area dark brown non-blanchable.
Right medial heel DTPI 2.0 cm x 1.5 cm area dark brown non-blanchable.

On December 15, 2016 at 12:15 PM E5 stated she was not aware of R20's DTPI, she said she will do the assessment of the R20's pressure injury. E5 also said R20's should be elevated on pillows to relieve pressure. E5 confirmed R20 is at high risk for the development of pressure injury and should be turned and repositioned at least every two hours, she should also use heel protectors and will order special mattress.

On December 15, 2016 at 12:05 PM E17 stated she positioned R20 at 8:00 AM on her back in supine position and since then she has been on her back. E17 also said she should have elevated R20's legs on pillows.

R20's October 17, 2016 Minimum Data Set (MDS) showed she needs extensive assistance of one person for her activities of daily living, frequently incontinent of bowel and bladder.

R20's July 20, and October 17, 2016 Braden Scale for Predicting Pressure Sore Risk showed she is at risk for acquiring pressure injury. The pressure sore risk factors included: limited sensory perception, constant moisture, chairfast, very limited mobility and friction and shearing. The facility did not analyzed these risk factors to develop individualized pressure injury prevention

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S9999	Continued From page 10 interventions. The facility also did not conduct a tissue tolerance test to develop turning and repositioning schedule. R20's preventative pressure injury plan of care dated May 4, 2016 which was updated on July 20, 2016 and October 17, 2016 interventions are generalized and vague. The examples of such interventions are: "observe skin routinely, preventative skin products." There are no interventions to use positioning devices to relieve pressure on her heels. (B)	S9999		