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| S 000 | Initial Comments<br><br>Annual Licensure and Certification.<br>Complaint Investigation 2123340/IL133907 | S 000 | | |
| S9999 | Final Observations<br><br>( 1 of 2)<br>Statement of Licensure Violations<br><br>300.675a)1)2)3)A-G)<br>300.675b)1)A-E)2)3)4)<br>300.675c)1)A-J)2)3)4)<br>300.675d)<br>300.675e)<br><br>Section 300.675 COVID-19 Training Requirements Emergency<br><br>a) Definitions. For the purposes of this Section, the following terms have the meanings ascribed in this subsection (a):<br><br>1) "CMMS (Centers for Medicare and Medicaid Services) Training" means CMMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management, available at https://QSEP.cms.gov.<br><br>2) "Frontline clinical staff" means the medical director of the facility, facility treating physicians, registered nurses, licensed practical nurses, certified nurse assistants, psychiatric service rehabilitation aides, rehabilitation therapy aides, psychiatric services rehabilitation coordinators, assistant directors of nursing, directors of nursing, social service directors, and any licensed physical, occupational or speech therapists. Any consultants, contractors, volunteers, students in any training programs, and caregivers who | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>provide, engage in, or administer direct care and services to residents on behalf of the facility are also considered frontline clinical staff.<br><br>3) "Management staff" means any facility staff who:<br><br>A) Assign and direct nursing activities;<br><br>B) Oversee comprehensive assessment of residents' medical needs and care planning;<br><br>C) Recommend numbers and levels of nursing personnel;<br><br>D) Plan nursing service budgeting;<br><br>E) Develop standards of nursing practice;<br><br>F) Supervise in-service education and skill training for all personnel; or<br><br>G) Participate in the screening of prospective residents and resident placement.<br><br>b) Required Frontline Clinical Staff Training<br><br>1) All frontline staff employed by facilities shall complete the following portions of CMMS Training:<br><br>A) Module 1: Hand Hygiene and PPE;<br><br>B) Module 2: Screening and Surveillance;<br><br>C) Module 3: Cleaning the Nursing Home;<br><br>D) Module 4: Cohorting; and | S9999 | | |

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| S9999 | Continued From page 2<br>E) Module 5: Caring for Residents with Dementia in a Pandemic.<br><br>2) Facilities shall ensure at least 50% of frontline clinical staff have completed the CMMS Training by January 31, 2021.<br><br>3) Facilities shall ensure 100% of the frontline clinical staff have completed the CMMS Training by February 28, 2021.<br><br>4) Facilities shall require, within 14 days after hiring, CMMS Training for all frontline clinical staff hired after January 31, 2021.<br><br>c) Required Management Staff Training<br><br>1) All management staff employed by facilities shall complete the following portions of CMMS Training:<br><br>A) Module 1: Hand Hygiene and PPE;<br><br>B) Module 2: Screening and Surveillance;<br><br>C) Module 3: Cleaning the Nursing Home;<br><br>D) Module 4: Cohorting;<br><br>E) Module 5: Caring for Residents with Dementia in a Pandemic;<br><br>F) Module 6: Infection Prevention and Control;<br><br>G) Module 7: Emergency Preparedness and Surge Capacity;<br><br>H) Module 8: Addressing Emotional Health of Residents and Staff; | S9999 | | |

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| S9999 | Continued From page 3<br>I) Module 9: Telehealth for Nursing Homes; and<br><br>J) Module 10: Getting Your Vaccine Delivery System Ready.<br><br>2) Facilities shall ensure at least 50% of management staff have completed the CMMS Training by January 31, 2021.<br><br>3) Facilities shall ensure 100% of management staff have completed the CMMS Training by February 28, 2021.<br><br>4) Facilities shall require, within 14 days after hiring, CMMS Training for all management staff hired after January 31, 2021.<br><br>d) By January 31, 2021, all facilities shall certify compliance, in the form and format specified by the Department, with subsections (b)(2) and (c)(2).<br><br>e) By February 28, 2021, all facilities shall certify compliance, in the form and format specified by the Department, with subsections (b)(3) and (c)(3).<br><br>These regulations are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure a newly hired staff member received the CMMS (Centers for Medicare and Medicaid Services) COVID-19 mandatory training within 14 days of hire. This failure has the potential to affect all 75 residents.<br><br>Findings include:<br><br>The facility's CMS (Centers for Medicare and Medicaid) Form 672 dated 5-25-21 and signed by | S9999 | | |

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| S9999 | Continued From page 4<br>V1 (Administrator) documents 75 residents reside within the facility.<br><br>V11's (Certified Nursing Assistant/CNA) Hire Form documents V11 was hired on 4-9-21.<br><br>V11's Course Completion History dated 5-25-21 documents, "CMMS Target COVID-19 training due 4-23-21. Course Status: Not competed."<br><br>On 05/25/21 at 02:30 PM V1 stated, "(V11/CNA) has not received the mandatory CMMS COVID-19 training. (V11) is a CNA and works in the entire facility as needed."<br><br>Violation " C"<br><br>( 2 of 2 )<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1010)h)<br>3001210b)<br>300.1210d)2)3)5)<br>Section 300.1220b)2)3)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and | S9999 | | |

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| S9999 | Continued From page 5<br><br>procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1010 Medical Care Policies<br><br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |

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| S9999 | Continued From page 6<br>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.<br>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:<br>2) All treatments and procedures shall be administered as ordered by the physician.<br>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.<br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br>2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, | S9999 | | |

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| S9999 | Continued From page 7<br>sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br>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.<br>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.<br><br>These Requirements were Not Met Evidenced by:<br><br>Based on observation, record review, and interview, the facility failed to follow facility policy and procedure related to pressure ulcers, ensure staff were knowledgeable in the assessment and staging of pressure ulcers, develop and implement pressure ulcer prevention interventions, perform treatments as ordered by the Physician, conduct ongoing wound assessments and provide timely turning and repositioning, for three of six residents (R23, R33 and R57) reviewed for pressure ulcers in a sample of 45. These failures resulted in the deterioration of R23 and R33's facility acquired | S9999 | | |

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| S9999 | Continued From page 8<br>pressure ulcers subsequently resulting in Stage 4 facility acquired pressure ulcers.<br><br>Findings include:<br><br>On 05/26/21 at 11:34 PM V2 (Director of Nursing) stated, "We (the facility) have identified issues with in-house pressure ulcer development. I think it is due to use of agency staff. The agency staff do not always know our policies and procedures and do not turn and re-position residents like they should."<br><br>On 5/26/21 at 12:21 PM, V2 stated the facility currently does not have a designated Wound Nurse or anyone Wound Care Certified. According to V2, all wound monitoring/assessments are completed by the floor nurse, which could be a Registered Nurse or Licensed Practical Nurse. V2 stated that nursing staff is responsible for the weekly monitoring of wounds, providing all ordered wound treatments, informing the Physician of changes in wounds, initiating a plan of care for wound prevention in the event of a decline in condition, and developing a plan of care for specific wounds identified. V2 stated frequent turning and repositioning of residents that are unable to do so for themselves is expected by staff to prevent wound development. V2 stated pressure ulcers are to be staged according to their policy and staff are not to stage wounds that have progressed to a prior stage (i.e., a Stage 4 can't later be called a Stage 2). V2 stated that nursing staff needed some education regarding accuracy of wound staging.<br><br>1. The Electronic Medical Record documents R33 was admitted to the facility on 6/02/15 with the diagnosis of Dementia. The Electronic Medical | S9999 | | |

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| S9999 | Continued From page 9<br><br>Record documents R33 had three different Braden Scales for Predicting Pressure Ulcer Risk assessments completed on 10/28/20, by three different nurses, all of which scored R33's risk of pressure ulcer development differently. One Braden Scale for Predicting Pressure Ulcer Risk assessment for R33 indicated a score of 17 (at risk), another a score of 13 (moderate risk), and another a score of 11 (high risk). Another Braden Scale for Predicting Pressure Ulcer Risk assessment completed on 1/01/21 scored R33 at 14 (moderate risk). R33's medical record contains no documented evidence the "High Risk or Moderate Risk Protocol", as outlined in the Wound and Ulcer Policy and Procedure, was followed. A Minimum Data Set assessment, completed on 1/01/21, documents R33 requires the extensive assistance of two staff for bed mobility and transfers with a mechanical lift. R33's Plan of Care, dated 1/01/21, documents, "(R33) is at risk for skin breakdown due to frequent urinary incontinence and the need for staff assistance with dressing, toileting, and grooming tasks" and instructs staff to use a pressure reduction mattress, perform daily skin assessments, encourage food/fluids, and provide prompt incontinence care.<br><br>A Wound Documentation Note, dated 1/27/21, documents R33 developed a Stage 2 Pressure Ulcer on the Coccyx, measuring 2.5 cm by 3.0 cm by 0.1 cm, and the wound was originally identified on 1/25/21; however, there are no initial wound measurements on 1/25/21. The Physician's Orders on 1/25/21 document staff were instructed to provide a specified wound treatment daily, lay R33 on her lateral sides in bed, turn every two hours, and reposition R33 hourly when up in the wheelchair/recliner. Treatment Administration Records for February | S9999 | | |

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| S9999 | Continued From page 10<br><br>2021 document staff failed to provide Physician ordered wound care on 2/01/21, 2/06/21 and 2/09/21. The next documented wound assessment was over two weeks later, on 2/13/21, when R33's Coccyx wound measured 3.25 cm by 3.0 cm by 0.2 cm. The following day, on 2/14/21, R33's coccyx wound increased in size, measuring 4.0 cm by 3.0 cm by 0.2 cm, with necrosis and drainage. The Physician's Orders on 2/14/21 document the wound care treatment was changed, with instructions to continue previously given repositioning instructions. R33's Plan of Care up to this point failed to identify that R33 has developed a pressure ulcer, or any new interventions related to pressure ulcer prevention, specifically a turning and repositioning program to decrease pressure on the Coccyx.<br><br>On 2/16/21, Wound Documentation notes indicate no measurable change in R33's coccyx wound. The next documented wound assessment was on 2/25/21, nine days later, when R33's coccyx wound measured 5.0 cm by 4.0 cm by 0.75 cm and was identified as a Stage 3 pressure ulcer. There is no documented evidence that R33's Physician was notified of the decline in the coccyx wound at that time and there was no change in treatment orders. The Physician's Orders document R33's coccyx wound treatment was changed on 3/01/21, with the same staff instructions to reposition R33 every two hours when in bed and every hour when in the chair.<br><br>Wound Documentation notes, dated 3/02/21, document R33's coccyx wound measured 4.5 cm by 4.0 cm by 1.0 cm, with evidence of slough, necrosis, moderate drainage, and tunneling of 1.0 cm deep. On 3/05/21, Nursing Progress notes document staff obtained an order for oral | S9999 | | |

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antibiotics, due to evidence of the coccyx wound being infected. Then, on 3/10/21, Wound Documentation notes for R33 indicate the coccyx wound had deteriorated to 5.0 cm by 5.0 cm by 6.0 cm and is described as "unstageable", with tunneling 6.0 cm deep, black/red slough, necrosis and "crater like." Nursing Progress notes on 3/10/21 document the Physician was notified, and pain medication was ordered, with no change in wound treatment. At this time, R33's Plan of Care still failed to identify that R33 had developed a pressure ulcer, or any new interventions related to pressure ulcer prevention, specifically a turning and repositioning program to decrease pressure on the Coccyx.

Nursing Progress notes, dated 3/12/21, document "(R33) has been resting quietly in her bed this shift. New order of Tramadol 50 (milligrams three times per day) for pain control during dressing changes approved 3/10/21. Upon entry of her room every 2 hours for repositioning, this RN observed her eyes wide open. Alert without verbal response. Wincing and facial grimacing also observed during each lateral alternating turn. Fluids encouraged. Dressing on coccyx (clean/dry/intact). Last doses of scheduled (antibiotic) due today. (Assistant Director of Nursing) aware. Afebrile. This (Registered Nurse) suggested another week of (antibiotic) for current wound healing as necessary. (Physician) was faxed overnight on 3/10/21 for approval, after her rounds at the facility earlier in the day. No response yet. (Physician) is usually out of the office on Thursdays. Anticipating a response today. (Physician) observation of resident's coccyx deterioration has not been confirmed thus far. Hands on treatment is imperative at this point. Compassion visits have been approved by facility

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| S9999 | Continued From page 12<br><br>administration. (Assistant Director of Nursing) is also aware of the need for Hospice evaluation and (Power of Attorney) notification of wound condition. Staff reports resident eats 50% on a regular basis. Discomfort continues indicated by tears and outbursts of "OUCH!!" Will communicate with day shift to reach out to (Physician) office by phone. Will reiterate importance to (Assistant Director of Nursing). Comfort will continue to be emphasized."<br><br>Nursing Progress notes dated 3/13/21 at 1:23 am, document "During shift report no updates (related to continued antibiotic) for wound to (R33's) coccyx. No response in the fax box to request dated 3/11/21. No documentation regarding a phone call to the (Physician) asking to refill Keflex 500 mg (twice per day). Will inquire with day shift why this issue was not followed up with during business hours." R33's Progress notes further document at 8:38 am, "(R33) in extreme pain overnight this shift. Facial grimacing, clenched fists, squinted eyes with intermittent tears. Tramadol 50 mg given at (2:30 am). When repositioned at (4:30 am), no relief apparent. No response from (Physician related to) extending (antibiotic). (Physician) paged twice. Spoke with (Physician), on call for (Medical Director) and was suggested to send her to (the Emergency Room) for proper wound treatment, observation, and pain management." Nursing Progress notes later document R33 was assessed in the Emergency Room and admitted to the hospital on 3/13/21.<br><br>On 3/16/21, Nursing Progress notes document R33 was readmitted to the facility with a Stage 4 Pressure Ulcer to the coccyx and treatment order for staff to clean the coccyx/tunneled area with normal saline, pack the wound with wet to dry | S9999 | | |

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| S9999 | Continued From page 13<br><br>dressing of Dakin's Solution and sterile gauze twice daily, and repositioning every two hours. There is no documentation of R33's wound being measured upon her readmission 3/16/21. Treatment Administration Records for March 2021, document staff failed to provide the Physician's ordered wound treatment on 3/19/21, 3/22/21, 3/24/21, 3/26/21, and 3/31/21. Physician's Orders document R33 was placed on Hospice on 3/19/21 for "Severe Protein-Calorie Malnutrition." On 3/23/21, R33's Plan of Care was updated to reflect the presence of Pressure Ulcers. The next documented wound assessment was on 3/24/21, nine days after R33 being readmitted, and described R33's coccyx wound as 4.3 cm by 5.5 cm by 3.3 cm and "Unstageable", even though it had been previously identified as a Stage 4 wound.<br><br>Nursing Progress notes and Wound Documentation indicate ongoing monitoring of R33's coccyx wound. Treatment Administration Records for April and May 2021 document staff failed to complete R33's wound care as ordered by the Physician on the following dates: 4/01/21, 4/02/21, 4/05/21, 4/07/21, 4/08/21, 4/09/21, 4/14/21, 4/15/21, 4/16/21, 4/18/21, 4/20/21, 4/25/21, 4/26/21, 4/27/21, 4/28/21, 4/30/21, 5/02/21, 5/07/21 and 5/10/21. On 5/24/21, Wound Documentation notes indicate R33's coccyx wound measured 3.0 cm by 3.5 cm by 3.0 cm.<br><br>On 5/24/21 at 10:05 am, R33 was sitting in her room in a recliner with a mechanical lift sling under her and continuous observation was started. At 12:29 PM, the licensed nurse went in to R33's room to administer medication and no repositioning was offered. At 12:34 PM, V13 and V27 (Certified Nursing Assistants) entered the | S9999 | | |

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| S9999 | Continued From page 14<br>room to transfer R33 to bed. At that time, V13 stated R33 had been up in her recliner since approximately 9:30 am. V13 and V27 provided R33 with incontinence care once she was in her bed. R33 had been incontinent of urine and once the incontinence brief was removed, the coccyx was noted to not have a dressing in place, and just packed with gauze. V13 stated R33's wound should have been covered with a secured dressing on top of the packed gauze. R33's recliner did not have a specialized cushion to off load pressure. V13 stated, because of R33's pressure ulcer, she is supposed to be repositioned every two hours by staff.<br><br>On 5/25/21 at 2:42 p.m., V6 (Registered Nurse) changed R33's coccyx dressing and R33 was observed to have an open wound, approximately the size of a golf ball with additional tunneling.<br><br>2. The Electronic Medical Record documents R23 was admitted to the facility on 3/20/18 with the diagnosis of Dementia. A Braden Scale for Predicting Pressure Ulcer Risk dated 9/14/20, scored R23 at a 20, which is low risk for the development of pressure ulcers. A follow up Braden Scale for Predicting Pressure Ulcer Risk, dated 10/27/20, scored R23 at a 16, which is mild risk for the development of pressure ulcers and reflects a health decline. On 10/29/20, R23's Minimum Data Set assessment documents she required the extensive assistance of one staff member for bed mobility and all Activities of Daily Living. A 10/29/20 Plan of Care documents R23 is at risk for impaired skin integrity, related to immobility and incontinence, and only instructs staff to follow Physician treatment orders per facility protocol, monitor nutritional status, and provide incontinence care after each episode. On 11/14/20, another Braden Scale for Predicting | S9999 | | |

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| S9999 | Continued From page 15<br><br>Pressure Ulcer Risk was completed and R23 scored a 12, indicating she was now at high risk for the development of pressure ulcers and further health decline. R23's Plan of Care fails to document any new interventions implemented at that time to prevent the development of pressure ulcers and R23's medical record contains no documented evidence of the implementation of the "High Risk Protocol", as outlined in the Wound and Ulcer Policy and Procedure.<br><br>Nursing Progress notes, dated 1/15/21, document, "(R23) has two pressure injuries observed; (R23) has a pressure injury to lower mid back and a pressure injury to right buttocks." Wound Documentation Notes, dated 1/15/21, document R23 as having a Stage 2 Sacral Wound, measuring 2.5 cm (centimeters) by 0.5 cm. Wound Documentation Notes and Nursing Progress notes do not contain any documented evidence that the lower mid back wound was measured and staged by the nurse, that the Physician was notified of either wound, that a treatment of any kind was initiated, or that any new interventions were implemented to prevent the wounds from deteriorating at that time.<br><br>On 1/22/21, Wound Documentation Notes document R23 as having an "in house acquired" Stage 2 Pressure Ulcer on the low back, measuring 1.0 cm (centimeters) by 0.5 cm by 0.1 cm, and a Stage 2 Pressure Ulcer on the Coccyx, measuring 6 cm by 3 cm by 0.1 cm. Physician's Orders document a treatment for both wounds was initiated on 1/22/21. R23's Plan of Care failed to identify any new interventions related to pressure ulcer prevention or her current wounds.<br><br>Wound Documentation notes, dated 2/03/21, document the Coccyx pressure ulcer increased in | S9999 | | |

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| S9999 | Continued From page 16<br><br>size and measured, 8.5 cm by 10 cm by 0.1 cm and the lower back pressure ulcer measured 1.0 cm by 0.25 cm by 0.1 cm. The following week, on 2/11/21, Wound Documentation Notes document both wounds increased in size and had evidence of necrotic tissue, with the Coccyx wound measuring 8.5 cm by 12.0 cm by 0.25 cm, and the lower back wound measuring 2.0 cm by 1.75 cm by 0.25 cm.<br><br>The Treatment Administration Record, document on 1/22/21, the Physician ordered staff to clean the Coccyx and lower back wounds with wound cleanser, apply Calcium Alginate and cover with a border foam gauze dressing twice per day; R23's medical record documentation indicates staff failed to perform the wound care as ordered by the Physician on 1/24/21, 1/26/21, 1/27/21, 1/30/21, 1/31/21, 2/01/21, 2/02/21, 2/05/21, 2/07/21, 2/08/21, and 2/09/21.<br><br>The facility failed to assess and measure R23's wounds the week of 2/18/21, which was the same week R23 was placed on Hospice care. The next documented wound assessment was on 2/28/21, 17 days later, in which the Coccyx wound measured 8.5 cm by 14 cm by 0.75 cm and the lower back wound measured 1.75 cm by 1.5 cm by 0.25 cm. Both wounds are documented to have continued necrosis. R23's Plan of Care failed to identify any new interventions related to pressure ulcer prevention or her current wounds.<br><br>On 3/02/21, the Wound Documentation notes document R23 had a Stage 3 Coccyx Pressure Ulcer that measured 9.0 cm by 14.0 cm by 0.75 cm. There was no change in size of the lower back wound.<br><br>On 3/09/21, Wound Documentation notes | S9999 | | |

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document R23 had a Stage 4 Coccyx Pressure Ulcer, measuring 14.0 cm by 9.0 cm by 2.5 cm, with slough, heavy drainage and "tunneling observed at 10 o'clock (approximately) 0.75 cm deep." On 3/11/21, the Wound Documentation notes document R23 has a Stage 3 lower back Pressure Ulcer that measured 2.1 cm by 1.5 cm by 0.5 cm. R23's Plan of Care failed to identify any new interventions related to pressure ulcer prevention or her current wounds, specifically a turning and repositioning program to decrease pressure on the Coccyx and low back.

The electronic medical record documents weekly wound measurements continued, along with various wound treatments. R23's Wound Documentation Notes, dated 5/18/21, document the low mid back wound as a Stage 3 pressure ulcer, measuring 1.6 cm by 0.8 cm by 3.6 cm (depth), and the Coccyx wound as a Stage 3 pressure ulcer, measuring 5.7 cm by 3.4 cm by 1.8 cm. R23's Current Plan of Care remains the same as it was on 10/29/20 which was prior to the pressure ulcers developing, only identifying R23 as being at risk for the development of Pressure Ulcers with the same interventions. Wound Documentation Notes, dated 5/22/21, document R23 now has an additional Pressure Ulcer located on her Right Ankle, measuring 1.8 cm by 1.6 cm by 0.3 cm.

On 5/25/21 at 9:23 am, V12 (Certified Nursing Assistant) had just finished feeding R23 breakfast, as R23 was lying in her bed, with the head of the bed elevated. At 10:00 am, V12 provided incontinence care to R23 and transferred R23 to a recliner in her room. The recliner did not have any pressure reduction cushion or pillows to shift R23's weight on her coccyx. R23 was observed continuously in the

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| S9999 | Continued From page 18<br><br>same position in her recliner, until 1:30 PM. During that timeframe, V12 did enter R23's room at 12:20 PM, but no repositioning was provided. At 12:40 PM, V12 entered R23's room again and asked R23 if she wanted to eat her lunch in her recliner or in her bed. V12 did not encourage R23 to reposition or offload the pressure to her coccyx, and R23 stated she would stay in her recliner for lunch. At 12:54, V12 did bring the head of the recliner up, so she could feed R23 her lunch; however, direct pressure remained on R23's coccyx. At 1:08 PM, V12 stated to R23, "You need to lay down and get off your bottom" and R23 agreed. At 1:30 PM, V13 (Certified Nursing Assistant) and V14 (Admissions Coordinator/Certified Nursing Assistant) transferred R23 with a mechanical lift to her bed. R23 was incontinent of feces and peri care was provided. R23 had intact dressings over an area of her lower spine and her coccyx. R23's vertebrae were very prominent and the skin over the vertebrae directly above the lower spine dressing was reddened. R23's lower buttocks was red and creased from sitting. R23 also had a dressing covering a pressure ulcer on her right inner ankle. After providing care, V13 positioned R23 on her left side, with pillows between her legs and a foam boot on her right foot. At that time, V12 confirmed that R23 is to be repositioned every two hours. V12 was questioned if they ever attempt to off load pressure to R23's coccyx or attempt to shift her weight while she is in the recliner and V12 stated "it's difficult" to offload pressure to R23's pressure ulcers, "because she has three of them."<br><br>On 5/26/21 at 12:30 PM, V21 (Medical Director) stated she is seeing a trend where individuals who normally might not have skin issues, get COVID and then develop pressure ulcers. V21 | S9999 | | |

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| S9999 | Continued From page 19<br>stated this can be attributed to their lack of desire to want to get out of bed, lack of appetite, and multiple other issues leading to a general decline. V21 stated R23 and R33, both developed COVID, and shortly after suffered from skin breakdown, leading to their Stage 4 Ulcers. V21 stated that accurate skin assessments, accurate identification of pressure ulcer risk and appropriate implementation of interventions would have been imperative in the attempt to prevent R23 and R33's wounds from developing/progressing.<br><br>3. R57's Minimum Data Set (MDS) assessment dated 3/25/21 documents that R57 had no functional limitations in range of motion to her upper and lower extremities at that time. This same MDS documents that R57 requires only supervision of one person for ambulation.<br><br>R57's Braden Scale for Predicting Pressure Ulcer Risk dated 3/25/21 documents R57 was at low risk for developing a pressure ulcer at that time.<br><br>R57's MDS dated 4/20/21 documents R57 was unable to walk, required extensive assistance of two people for bed mobility and transfers; and had a functional limitation in range of motion to one upper and one lower extremity.<br><br>R57's fall investigation dated 4/7/21 documents R57 fell on her left side while in the bathroom resulting in hospitalization for left hip and left wrist fractures.<br><br>R57's Nurse's notes dated 4/12/21 document that R57 was readmitted to the facility following surgical repair to R57's fractured left hip and wrist. These Nurse's notes do not document any | S9999 | | |

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| S9999 | Continued From page 20<br><br>measures were put into place to address R57's decrease in mobility or for pressure ulcer prevention. R57's Nurse's note dated 4/17/21 document that R57 had functional impairment in range of motion to one upper and one lower extremity, had an incision to the left hip and a cast to the left arm.<br><br>R57's medical record does not include any additional Braden Scales for Predicting Pressure Ulcer Risk following R57's readmission from the hospital to determine if her decreased mobility put her at increased risk for the development of pressure ulcers until 5/8/21.<br><br>R57's Nurse's note dated 5/3/21 documents R57 developed a large fluid filled blister on her left heel. This note does not include documentation that interventions were put into place to treat or to relieve pressure from R57's left heel. R57's Nurse's note dated 5/8/21 documents that a pressure ulcer risk assessment was done at that time and found that R57 was now considered at risk for developing pressure ulcers. This same Nurse's note has an area to list clinical suggestions to address R57's pressure ulcer risk but no clinical suggestions are listed. R57's Nurse's note dated 5/10/21 documents R57's, "Blister to heel is now open. Entire area is dark red in color, tender to touch." R57's Nurse's note dated 5/12/21 documents that R57's left heel wound had developed serosanguinous (blood tinged) drainage and yellow slough.<br><br>R57's Wound Documentation form dated 5/2/21 at 12:05 a.m. documents a pressure ulcer was initially identified to R57's left heel measuring 7.5 cm (centimeters) long x 9.5 cm wide on that date, which developed at the facility. This wound documentation does not identify the stage of this | S9999 | | |

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| S9999 | Continued From page 21<br>wound, however, a description of pressure wound stages listed on the form describes a blood-filled blister as a suspected deep tissue injury.<br><br>R57's Wound Documentation form dated 5/13/21 documents R57's left heel pressure wound had deteriorated into a Stage 2 pressure ulcer measuring 8.5 cm long x 9.5 cm wide x 0.25 cm deep. A description of the wound is documented as, "Blister opened at some time. Now (with) yellow slough at times, with serous drainage." A description of pressure wound stages on the form describes a stage 2 pressure ulcer as being without slough, but a pressure wound with slough is describes as either a stage 3, stage 4, or an unstageable pressure ulcer.<br><br>R57's Care Plan does not document a plan with interventions to prevent the development of pressure ulcers until 5/24/21, after R57's left heel pressure ulcer had already developed.<br><br>On 5/24/21 at 3:44 p.m. V18 (Licensed Practical Nurse/LPN) stated she was the nurse to initially find R57's left heel wound and obtain treatment orders. V18 stated that R57's wound started out as a black fluid filled blister which deteriorated to a black flattened area. V18 stated that R57 was admitted to the hospital on 5/16/21 then returned 5/20/21 and that is when a pressure relief boot was ordered for R57's leftfoot. V18 stated that there is no trained wound nurse or wound specialist who evaluates, measures, and treats wounds at the facility. V18 stated that every Tuesday R57's wound is measured and described by whoever is R57's nurse that day.<br><br>On 5/26/21 at 10:51 V15 (Certified Nurse Aide/ CNA) stated she was one of R57's regular CNAs. V15 stated that CNA staff were not given any | S9999 | | |

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| S9999 | Continued From page 22<br>instructions for turning, repositioning, or relieving pressure from R57's heels when she returned from the hospital following R57's fall with fracture to her left hip and left wrist on 4/12/21. V15 stated that R57 did not have a pressure relief boot for her left foot until she returned from the hospital on 5/20/21.<br><br>R57's CNA Intervention/Task sheets, which instruct CNAs on what cares and interventions should be done for each resident, dated 4/1/21 to 5/26/21 do not include a program for turning, repositioning, or elevating R57's heels for pressure relief.<br><br>On 5/24/21 at 3:44p.m. V18 removed the dressing from R57's left heel pressure ulcer. R57's left heel had a large round wound which was covered with blackened tissue and which encompassed R57's entire heel.<br><br>On 5/26/21 at 8:50a.m. V2 (Director of Nurses/DON) stated that inconsistency among nursing staff for determining the stage of pressure ulcers has been a problem at the facility. V2 stated that he looks at the wound reports once a resident develops pressure ulcers but does not evaluate the wounds to determine if they are staged appropriately. V2 stated the facility does not have a certified wound nurse or a wound specialist to evaluate wounds. V2 stated that R57 did not have weekly Braden scoring done to determine whether R57 was at increased risk for pressure ulcers once she returned from the hospital 4/12/21 following a fracture to her left hip and left wrist. V2 stated that R57 should have had pressure ulcer preventive measures put into place once she was no longer independently mobile. V2 stated that at the time of R57's fall, she was independent with walking, turning, and | S9999 | | |

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| S9999 | Continued From page 23<br><br>repositioning but after fracturing her left hip, R57 was no longer able to walk which makes her more dependent on staff for mobility. V2 stated that the facility should have developed a plan of care to include pressure ulcer prevention measures before R57 developed a left heel pressure ulcer on 5/2/21. V2 stated that staff should have ensured R57's heels were elevated to prevent the development of R57's left heel pressure ulcer.<br><br>The facility policy, titled "Wound and Ulcer Policy and Procedure (revised 1/10/2018)," documents, "It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. Procedure: All residents will be assessed to determine the degree of risk of developing a pressure ulcer using the Braden Scale Ulcer Risk Assessment. The resident will be assessed upon admission, once a week for four weeks, and monthly thereafter. Protocols may include any or all for the following based upon the needs and condition of the resident. Additional measures may be added at the discretion of the facility."<br><br>The policy outlines a "Moderate Risk Protocol" as the following, "Daily skin check - completed by direct care staff. The 'Skin Observation Report' may be used to communicate skin observation(s) or changes to the nurse. Mattress with documented pressure reducing/relieving properties may be placed on the resident's bed. If appropriate, a cushion with pressure reducing/relieving properties may be used in the resident's chair. If incontinent, care may include the use of barrier creams to minimize the effects of urine and feces on the skin. Range of motion | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6009245 | A. BUILDING: _____ B. WING _____ | 05/27/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNNY ACRES NURSING HOME | 19130 SUNNY ACRES ROAD PETERSBURG, IL 62675 |

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| S9999 | Continued From page 24<br>and turning and positioning will be provided if clinically indicated.<br><br>The Dietary Manager will evaluate the resident quarterly for nutritional factors and recommend interventions as needed. Approaches will be placed in the resident care plan. Changes in condition (activity level, mental status, mobility, nutritional status, incontinence) are promptly reported." The policy further outlines a "High Risk Protocol" as the following, "Residents with existing ulcers will be deemed as high risk for impaired skin integrity despite the Braden Risk Assessment Score. Daily skin check - completed by direct care staff.<br><br>The 'Skin Observation Report' may be used to communicate observations or changes to the nurse. Specialty mattress (low air loss, alternating pressure, etc.) with enhanced pressure reducing/relieving properties may be placed on the resident's bed and chair as indicated. Skin contact surfaces may be padded to protect bony prominences. Range of motion may be provided if clinically indicated. The resident may be placed on a turn and reposition schedule if clinically indicated. Dietitian may recommend monthly evaluation of the resident. A resident with existing skin breakdown will be evaluated monthly. Approaches will be placed in the resident's care plan. Changes in condition are properly reported."<br><br>The policy also documents, "When a resident is found to have a wound (or ulcer, our licensed nurse will complete), either on admission or during their stay, the following: Document assessment of the wound/ulcer in the medical | S9999 | | |

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| S9999 | Continued From page 25<br>record. Initiate the treatment protocol appropriate for the stage of ulcer or for the wound assessed. The classification and treatment of wounds, including ulcers, will follow the wound management program protocols for the wound type/ulcer stage assessed unless otherwise specified by the Physician.<br>Document wound/ulcer treatment provision on the treatment administration record (eTAR). Notification of the Physician, documenting, and initiating ordered treatment. Transcribing, documenting, and initiating written and/or verbal orders of the Physician. Orders for Vitamin C 500 mg (milligrams) daily and/or Zinc Sulfate 220 mg daily and/or MVI (multi-vitamin) daily may be requested in addition to treatment of and ulcer. Notification of the Power of Attorney for Healthcare regarding change in the resident's condition. Care interventions for staff involved in the resident's care are communicated via the resident care plan. Assessment of progress toward healing is completed at least weekly and the Physician is notified at least monthly of progress toward healing. If there is regression, the Physician is notified of the condition change. Treatment continues per the Physician orders until the wound and/or ulcer is healed."<br><br>Violaton " B " | S9999 | | |