| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058198 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/17/2025 |
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| HIGHLIGHT HEALTHCARE OF AURORA | 1017 WEST GALENA BOULEVARD , AURORA, Illinois, 60506 |

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| S0000 | Initial Comments<br><br>Complaint Investigations 2576029/IL195737 (1192140), 2576175/IL196047 (1192136), and 2576231/IL195995 (1192135) | S0000 | | 08/10/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>1 of 2<br><br>300.610 a)<br><br>300.3210 a)<br><br>300.610. Resident Care Policies<br><br>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.<br><br>300.3210<br><br>a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act)210. General<br><br>These requirements are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to document a resident's discharge correctly for | S9999 | | 08/10/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>1 of 3 residents (R2) reviewed for discharge. This failure resulted in R2 losing his Medicare coverage from 5/17/2025-7/14/2025, having to cancel important diagnostic testing and a follow-up appointment with his neurosurgeon, not having CPAP (continuous positive airway pressure) supplies due to lack of medical coverage, and having to spend many hours and days trying to get his Medicare coverage reinstated.<br><br>The findings include:<br><br>R2's Admission Record, printed by the facility on 7/10/2025, showed he had diagnoses including, but not limited to partial intestinal obstruction, type II diabetes mellitus with hyperglycemia, gastrointestinal hemorrhage, anemia, acute kidney failure, neoplasm of unspecified behavior of bone, soft tissue, and skin, long-term use of non-insulin antidiabetic drugs, hypertension, anuria, and oliguria (reduced urine output or complete absence of urine output). The Admission Record showed R2 was discharged to home on 4/10/2025. R2's progress note, dated 4/10/2025, showed R2 was discharged to home with his wife (V9).<br><br>R2's Oder Summary Report, provided by the facility on 7/10/2025, showed an order for blood glucose checks daily. The report showed Patient may discharge to home 4/10/2025 with orders for Home Health care services to be provided by (name of home health services company) for PT/OT, Nursing, CNA, and DME (medical equipment) to include a wheelchair. The Report also showed needs appointment in June 2025 for MRI per neurosurgeon.<br><br>R2's Progress Note, dated 4/10/2025, showed R1 transported home with wife via (transportation service) at 10:15 AM.<br><br>The facility's Admission, Discharge, and Transfer Report, printed by the facility on 7/10/2025, lists R2 as deceased.<br><br>On 7/10/2025 at 8:35 AM, R2 said he discharged from the facility to home on 4/10/2025. R2 said he had to cancel his scheduled MRI (Magnetic Resonance Imaging) and an appointment with his neurosurgeon, due to the facility putting him down as deceased, causing him to lose his Medicare coverage. V9 (R2's wife) was also on the phone and said R2 was not able to schedule any appointments to have his stage 1 pressure ulcer looked at, adding he has a lot of medical issues and needs to see his doctors. V9 said she kept a log of everything and would email IDPH (Illinois Department of Public Health) the specific details of everything they had to do to get the facility's error resolved. | S9999 | | |

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| S9999 | Continued from page 2<br><br>On 7/10/2025 at 5:11 PM, V9 sent an email to IDPH that described the difficulties R2 encountered as a result of the facility incorrectly documenting R2's discharge as deceased.<br><br>On 7/14/2025 at 3:02 PM, V9 sent an email to IDPH with an update showing R2's Medicare account was active as of today.<br><br>On 7/15/2025 at 5:01 PM, V9 said, "The facility error has taken up a lot of our time and has been very stressful on him." R2 agreed. "We have been through a lot. (R2) and I have not been able to do anything because they have been on the phone trying to get it taken care of. (R2) was going to ask his neurosurgeon at his next appointment about an order for therapy, but the appointment had to be canceled due to the facility entering (R2) as deceased. Medicare would not cover the cost for (R2's) lancets and glucose test strips because the facility marked him as deceased. (R2) ran out of his CPAP (continuous positive airway pressure) supplies, and had to sleep without his CPAP for about 30 days, because he did not have the supplies. He did have trouble sleeping." R2 agreed. V9 said, "(R2) was so mad because the facility was not returning our calls. It was very frustrating. He missed the MRI scheduled for 6/23/2025 and the follow-up appointment on 6/30/2025. They had to be cancelled due to facility's mistake. (R2) just found out yesterday that it has finally been resolved, and (R2's) Medicare was reinstated. Billing departments from the hospital kept calling us and asking when the issue was going to be resolved so they could resubmit their claims. (R2) and I were told the date the facility's error went through the system on 5/17/2025. If we wanted to schedule any appointment, they would tell us we had to pay up front. We can't afford to do that. That is what we are paying the insurance company for. We felt the facility did not care about us. Like we were not important, like trash. No one should have to go through that."<br><br>On 7/10/2025 at 1:44 PM, V15 (Regional Business Manager for the facility) said, "The nurse that discharged (R2) entered him into PCC (the facility's electronic medical record charting system) as discharged expired. We take that information from PCC, and that is how we enter it for billing purposes." V15 said she was notified on 6/29/2025 that R2 went to make an appointment recently, and that is when R2 and V9 found out about the error. V15 said she was informed R2 missed a neuro appointment and some kind of test for his neuro appointment. V15 said she contacted Medicare and informed them that was an error. V15 said she contacted R2 and V9 to inform | S9999 | | |

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| S9999 | Continued from page 3<br>them it was corrected and would take about 7-10 business days. V15 said yesterday (7/9/2025) was business day 4. V15 said she informed R2 if it has not been corrected by Tuesday, to give her a call and she would take care of it. V15 said, "Medicare does not require a death certificate to stop Medicare coverage. Social Security needs one wrong key stroke and it could interfere with the resident's benefits. All the more reason to make sure that the information is entered in correctly. The nurse should make sure when they enter discharge information, they enter the correct information. If the nurse puts something in the system, the Business Office Manager (BOM) does not have access to the clinical side. The facility can put something in place where if someone is listed as expired, that we verify before we enter it into the Medicare billing. We can change how we are doing it to make sure that when a resident is entered as expired or deceased that we (the BOM) verify with the facility that the resident has expired before they enter information into the system, regardless of whether or not the resident is Medicare or Medicaid, so there is no disruption in the resident's Medicare coverage."<br><br>On 7/10/2025 at 3:00 PM, V8 (Registered Nurse-RN) said she was the nurse on duty that discharged R2 home with his wife. V8 said there is a place in PCC to enter whether the resident was discharged home, to a hospital, deceased, etc. V8 said she usually does not enter information to take a resident out of the system in case someone still needs to document on them. V8 said R2 was "very much alive". V8 said, "It is important to make sure you enter information into the system correctly for the billing, financial aspect, as well as for the resident, so it does not delay their medical care."<br><br>On 7/10/25 at 3:12 PM, V1 (Administrator) identified V14 (second shift nurse) entered it incorrectly in the system. V1 said he thinks V14 went to edit R2 in the system and mistakenly checked deceased instead of discharged to home.<br><br>On 7/11/2025 at 7:41 AM, V14 said she may have been the one that took R2 out of the system, she does not recall. V14 said no one has said anything about there being an error yet to her. She said she would talk to V1 and see what might have happened. She said it is important to make sure you document correctly whether a resident is discharged to home or discharged due to being deceased. V14 said R2 went home with his wife (V9).<br><br>On 7/16/2025 at 8:56 AM, V16 (Social Services Director) | S9999 | | |

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| S9999 | Continued from page 4<br>said she was not the one that took R2 out of the system. "I do not do that. If I print out a form, my name would be at the top as the user. I did not print out any forms for (R2) or (V9), or for anyone related to this issue. (R2) was at the facility for short-term therapy. He discharged to home with his wife. When (R2) and (V9) mentioned that he was ready to go home, we started putting things in place like home health services. We did not try to prolong the discharge. We just had to get everything set up to ensure a safe discharge for (R2)."<br><br>On 7/16/2025 at 10:18 AM, this surveyor called V21's (R2's neurosurgeon's) office and asked V21 to return the call to discuss what the follow up appointments for R2 were for and how the delay could affect R2. At 11:30 AM, V19 (V21's nurse) returned call. V19 said she would let V21 know the reason for the call and ask him to return this surveyor's call. No return call was received prior to exiting the facility on 7/17/2025.<br><br>On 7/16/2025 at 1:56 PM, V12 (facility's Medical Director) was informed about the discharge to home for R2 being incorrectly documented as deceased. V12 said, "Oh no". V12 was informed the error caused R2 to lose his Medicare coverage. V12 said, "You mean he had to go for months without insurance?" V12 said it is important for the nursing staff to make sure they enter information into the system carefully, so they do not kick a resident off their Medicare, or other insurance. V12 said this is the first time he was hearing of this.<br><br>The facility's policy and procedure titled Transfer and Discharge (including AMA), with a review date of 11/2024, did not include how to remove a resident from the facility electronic system when a resident is discharged.<br><br>(B)<br><br>2 of 2<br><br>300.610 a)<br><br>300.1210 b)<br><br>300.1210 d)2)<br><br>300.1210 d)3)<br><br>300.1210 d)5) | S9999 | | |

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| S9999 | Continued from page 5<br><br>300.610. Resident Care Policies<br><br>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.<br><br>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 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><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><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><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><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. | S9999 | | |

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| S9999 | Continued from page 6<br>These requirements are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure dressing changes were done as ordered (R1), and failed to ensure weekly wound assessments and documentation of the assessments were completed, for 2 of 5 residents (R1, R4) reviewed for non-pressure wound care in the sample of 6.<br><br>This failure resulted in R1's wound getting a maggot infestation, and the wound dehiscing and getting infected. R1 was sent out to a local emergency room, diagnosed with osteomyelitis, requiring two intravenous (IV) antibiotics to prevent sepsis, surgical intervention, and critical care hospital admission.<br><br>The findings include:<br><br>1. R1's Admission Record, provided by the facility on 7/10/2025, showed she had diagnoses including, but not limited to, transient cerebral ischemic attack (stroke), atherosclerotic heart disease, aneurysm of the ascending aorta without rupture, myocardial infarction (heart attack), cellulitis of unspecified part of limb, and hypertension.<br><br>R1's Discharge Instructions from a local hospital, dated 6/26/25, showed Wound Care: Dressing to be left in place until seen in the office next week. Do not get wet.<br><br>R1's 7/1/2025 notes from the follow up appointment showed Wound cleansing and dressings. Dry protective dressing. Do not get wet. The document showed V4 (LPN) clarified the order to be done every other day.<br><br>R1's Order Summary Report, provided by the facility on 7/10/2025, showed an order, dated 7/1/2025, for Wound #3 right toes area of great toe, 2nd toe, 3rd toe. Wound cleansing and dry protective dressing to be changed every other day.<br><br>R1's July 2025 Treatment Administration Record (TAR) showed no treatment was documented as being completed from 7/2/2025-7/6/2025.<br><br>The facility's weekly Skin Condition Report, dated 7/4/2025, showed R1 had arterial ulcers to her right | S9999 | | |

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| S9999 | Continued from page 7<br>posterior leg, right medial great toe, right second toe and her right third toe. V3 said the measurements on the form were taken from notes from the wound clinic R1 goes to.<br><br>R1's Progress notes from 7/1/2025-7/5/2025 do not document any dressing change to the surgical site on R1's right foot/toes area. The progress notes only show RLE ((right lower extremity) wound documentation, which was a different wound on R1's right posterior lower leg. There was no documentation of a dressing change or assessment to R1's right foot surgical site until 7/6/2025 at 8:20 PM where it showed, "Resident noted with an excessive amount of exudate drainage and possible presence of larvae in wound during wound care. MD (doctor) made aware and gave orders to send resident out for further eval (evaluation)."<br><br>R1's progress note, dated 7/6/2025 at 9:20 PM, showed R1 was noted with an excessive amount of exudate drainage and possible presence of larvae in wound during wound care, Doctor made aware and gave orders to send resident out for further evaluation. when an excessive amount of drainage and larvae were found on R1's right foot surgical wound and she was sent to a local hospital.<br><br>R1's progress notes from 7/1/2025-7/6/2025 do not show any documentation<br><br>R1's 7/6/2025 Emergency Department Physician Report from a local hospital showed, "Right foot with multiple toe amputations, extensive wound at distal tip with sutures, wound dehiscence, necrotic tissue, copious maggots cleaned from wound, mild surrounding erythema with warmth." the notes showed, "Admission is required due to the severity of the right foot wound infection with suspected osteomyelitis, need for IV antibiotics, and risk of clinical deterioration." The notes showed Critical Care Statement: "Given the patient's presentation with a right foot wound infection and osteomyelitis, which carried a high-risk for rapid clinical deterioration due to potential progression to severe sepsis or septic shock. The emergency room doctor provided 40 minutes of critical care time exclusive of other billable procedures. this time was spent in direct patient care involving high-complexity medical decision making and required constant attendance to prevent sudden, significant deterioration in the patient's condition." | S9999 | | |

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| S9999 | Continued from page 8<br><br>The Podiatry Consultation Physician's Report, dated 7/7/2025, showed R1 "had surgery approximately two weeks ago due to amputation of the first, second, and third digits of the right foot. This was due to gangrenous changes due to severe peripheral arterial disease. Patient was seen in the office for follow-up and incision site looked good with the wound edges well coaptated and sutures in place. Patient presented to the emergency room last night with dehiscence of the wound and maggots in the wound. The physician debrided the wound and the maggots out." The notes showed R1 was started on IV antibiotics and admitted for further workup. V6's operative notes on 7/8/2025 showed R1, "was placed under general anesthesia, the sutures were still in place, however they were not holding any skin or flaps at this time. The sutures were all removed. the wound base and wound edges were debrided back to healthy tissue...several dead bodies of maggots were noted...bony exposure is noted in the wound site. A wound was also noted on the medial aspect of the first metatarsal phalangeal joint area that was likewise debrided...Surgery site was dressed and covered...The area was anesthetized, and patient was extubated...Patient will continue antibiotics."<br><br>On 7/9/2025 at 3:46 PM, V7 (R1's Power of Attorney/POA) said, "(R1) had surgery on 6/25/2025 to amputate her toes. After a brief hospital stay, she returned to the facility. She had a follow up with the surgeon on 7/1/25. The doctor said it was healing nicely on her 7/1/2025 follow up appointment, and everything was okay at that point." V7 said he had not heard any updates from the facility until Sunday night (7/6/2025) after R1 was sent out to the hospital. V7 said the facility staff were supposed to look at her wound every two days. V7 said, "Someone from the emergency room (ER) called me on 7/6/2025 and told me (R1) was at the hospital and there were maggots in her surgical wound. (V4, Licensed Practical Nurse-LPN) from the facility called me 10 minutes later. By the time I arrived at the hospital, the emergency room staff had already gotten the maggots out of her wound. There were three maggots in a specimen cup and at least 10 more in a baggie. The reason for (R1's) toes being amputated was due to poor circulation to her feet. Some days (R1) is coherent, but lately she is not as coherent." V7 said he did not think R1 understands why she is in the hospital and did not feel that R1 would be able to say if the facility was doing the dressing changes as ordered. V7 said he spoke with V1 (Administrator) and V2 (Director of Nursing), and they said the facility | S9999 | | |

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| S9999 | Continued from page 9<br>was doing the dressing changes as ordered. V7 said R1 had to have her surgical site debrided (surgical removal of non-viable tissue). V7 said, "It is just too much. This should not have happened."<br><br>On 7/10/2025 at 10:48 AM, V2 (DON) was shown R1's July 2025 Treatment Administration Record (TAR). V2 said the dressing change for R1's right surgical site/wound in her toes area is not marked off as being completed 7/2/2025-7/6/2025.<br><br>On 7/11/2025 at 11:50 AM, V3 (Wound Nurse) said the wound clinic provided notes regarding wounds for R1. V3 said the facility got an order to clean the wound and do a dry dressing every other day on 7/1/2025. V7 said he did not do any dressing change or assessment of R1's amputation site. V3 said he did not see any documentation of an assessment being done by any other nurse for R1's surgical site on her right foot in her electronic medical record. V7 said surgical sites should be monitored, assessed, and the assessment should be documented. At 12:51 PM, V3 said, "It is important to monitor surgical sites for signs and symptoms of infection, wound dehiscence, a decline, or any changes, and to notify the surgeon of any changes." At 2:11 PM, V3 said the last assessment of R1's right toes, with measurements, was on 6/20/2025. V3 said, "When (R1) came back from surgery on 6/26/2025, there was an order to leave covered until her follow up appointment. (R1's) follow-up was on 7/1/2025. The doctor gave an order to cleanse the site and cover with dressing every other day. There was no dressing change completed, no facility assessment, or measurements that I can tell from 7/1/2025-7/6/2025 for (R1's) right foot." V3 said he will do the assessment and dressing change for the residents that are followed by the wound doctor that comes to the facility. He said he does not do the assessments and dressing changes for the residents that go out to wound clinic. V3 provided R1's Skin Impairment/Wound forms for 6/26/2025 and 7/1/2025. V3 said he got the information for the forms from the wound clinic, and did not do the assessments himself.<br><br>On 7/10/2025 at 3:20 PM, V4 (Licensed Practical Nurse-LPN) said V5 (Certified Nursing Assistant-CNA) told her it looked like the bandage on R1's right foot had some blood on it. V5 said she went in to check it and thought to herself "that is not blood. It had a slight odor, and brown drainage was on the sock." V4 said as she was unwrapping the bandage, she saw maggots on the bandage. She notified R1's doctor and he said to | S9999 | | |

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| HIGHLIGHT HEALTHCARE OF AURORA | 1017 WEST GALENA BOULEVARD , AURORA, Illinois, 60506 |

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| S9999 | Continued from page 10<br>send her out to the emergency room (ER) for evaluation. V4 said she worked on 7/1/2025. She called the doctor to verify the treatment orders. V4 said the order was to do the dressing change every other day. V4 said she had not done any assessment or dressing change for R1, because she did not work again until 7/6/2025. V4 said she started her shift at 2:00 PM on 7/6/2025. V4 said she did not recall seeing a date on the dressing, but she was also concerned with what was going on. "The color and smell of the drainage is what was concerning me. (R1) was having pain that day. Normally we don't have to give her anything for pain until about 8:00 PM. That day she was having more pain than normal." V4 said as she was unwrapping the bandage to R1's foot, R1 voiced it hurt and pulled back her foot. "I had to stop because it was hurting her too much. She was saying 'Oh, Oh, Oh.'" V4 said when she saw the maggots, she stopped, called the doctor, and about 15 minutes later, R1 was going out the door. V4 said based on the odor and drainage, she felt it could have been noticed earlier. There was a strong smell and the bandage was saturated. V4 said, "It is important to make sure to assess wounds to make sure the wound does not get infected, to notice right away and catch it before it gets bad, and update the doctor, to see if he wants to give any new orders. The earlier you catch something the better."<br><br>On 7/11/2025 at 2:53 PM, V5 (Certified Nursing Assistant/CNA) said he worked the shift that R1 was sent out to the hospital. He said, "I was assisting an agency CNA with (R1) and noticed something on the dressing at the top of her foot, where she had the surgery. It was dark in color, something unusual that you would not see on a sock. It did not really look like blood. It was discolored. I went to (V4) and asked her to check (R1's) foot and then went to assist other residents." V5 said he saw R1 leaving on a stretcher. He went into her room after hearing what happened and checked the linen on her bed. V5 said he saw 8-10 maggots on R1's linen, so he threw her linen away in the garbage.<br><br>On 7/11/2025 at 3:05 PM, V1 (Administrator) and V2 (Director of Nursing-DON) agreed it is important for the nurses to do an assessment on residents with wounds, at least weekly, even if the resident goes out to the wound clinic. V1 and V2 said unless there is an order not to touch the dressing, it is important the facility nurses assess the resident's wound to monitor and determine if the wound is improving or getting worse, so the doctor can be updated, and new orders can | S9999 | | |

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| S9999 | Continued from page 11<br>be received if needed.<br><br>On 7/15/2025 at 10:31 AM, V6 (Wound Clinic Doctor) said R1 "had her great toe, second and third digits on her right foot amputated on 6/25/2025. She stayed in the hospital overnight and was sent back to the facility on 6/26/2025. I gave an order to not touch the dressing until her follow-up appointment. When I saw her on 7/1/2025 for the follow-up, the wound was a closed surgical site, no opening, drainage or swelling. It looked very good." V6 said, "I gave orders on 7/1/2025 to change the dressing every other day. Keflex was ordered prophylactically to prevent infection. The next time I saw (R1) was the day after she was sent to the hospital (7/7/2025). The stitches were no longer holding the tissue together. It was an open wound. (R1) had the wound cleaned out in the ER due to there being maggots in the wound. On 7/8/2025, I had to take out all the stitches, which were still there, but not holding the tissue in place, debride the wound and flushed it out. Bone was exposed. When bone is exposed to the air, you assume it is infected. Osteomyelitis can occur." V6 said R1 was tested for, and he believes she was diagnosed with, osteomyelitis. "The wound was infected and had an infestation of maggots. Two antibiotics were given intravenously (IV) for broad-spectrum antibiotic therapy. It was very serious. Infestation and infection. Infection could get in the blood and the patient could become septic. It is important for the facility nurses to do the dressing changes as ordered. If not done as ordered, it will slow the wound healing and increase the risk of infection. I would expect the nurses to assess the wound during the wound changes, so if there is a problem, they could contact me for guidance on how to proceed." V6 said he has a 24-hour answering service. V6 said, "If the facility would have done the dressing changes and monitored the surgical site, it may have prevented the wound from getting infected and infested with maggots, and I would not have had to perform the surgical debridement procedure."<br><br>On 7/16/2025 at 8:24 AM, V1 (Administrator) said, "When (R1) came back from her follow up appointment on 7/1/25, there was some ambiguity about the orders. (V4, LPN) called the doctor and clarified the order. (V4) entered the order into the system wrong. She entered it into other orders (no documentation required), not into the Treatment Administration Record (TAR). When an order is entered into the system like this, the nurses cannot see the order." V1 said he investigated what happened, however, he did not document his | S9999 | | |

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| S9999 | Continued from page 12<br>investigation. V1 said the order was discontinued on 7/6/2025 and entered in the system correctly. V1 said V3 (Wound Nurse) could have followed up to see what the new orders were after her follow up visit and made sure the treatment was being done as ordered, just like any management team member is expected to do with their department. V1 said he let V2 (DON) know the nurses need training on entering medication orders because that is not acceptable. V1 was asked if the nurses that worked on all three shifts from 7/2/2025-7/6/2025 should have verified the orders for R1 after her follow-up appointment to make sure there was no treatment ordered. V1 nodded yes.<br><br>On 7/16/2025 at 1:56 PM, V12 (facility's Medical Director) said, "Some residents go out for wound care, then come back to the facility. They are here for us to provide medical care. It is important to follow the doctor's orders for wound care. If a resident goes out for wound care and comes back with an order to do dressing changes, the facility nurses should be doing their own wound assessment with every dressing change, document their findings, and notify the physician if there are any changes."<br><br>The facility's 10/2023 policy and procedure, titled Wound Treatment Management, showed to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician's orders…1. Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, and frequency of dressing change…8. The effectiveness of treatments will be monitored through ongoing assessment of the wound.<br><br>2. R4's Admission Record, provided by the facility on 7/16/2025, showed diagnoses including, but not limited to type II diabetes mellitus with diabetic neuropathy (a type of nerve damage that can occur with diabetes. Symptoms include pain, numbness, and slow healing of leg or foot sores), hypertension, congestive heart failure, acquired absence of left leg below the knee, iron deficiency anemia, ischemic cardiomyopathy, acute hematogenous osteomyelitis, chronic obstructive pulmonary disease, and acquired absence of right foot.<br><br>R4's Order Summary Report, printed by the facility on 7/11/2025, showed an order, dated 7/11/2025, to clean wound on right foot with normal saline. Apply xeroform to wound. Cover with abdominal pad and (rolled gauze) | S9999 | | |

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| S9999 | Continued from page 13<br>once daily and as needed. The report showed an order, dated 7/11/2025, for a nuclear stress test on 7/21/2025 (a cardiac imaging procedure that assesses blood flow to the heart muscle at rest and during stress. It helps doctors diagnose coronary artery disease and determine the extent of any blockages or damage).<br><br>R4's care plan, dated 5/20/2025, showed, "Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations."<br><br>R4's July 2025 TAR showed the dressing changes were being done as ordered.<br><br>On 7/10/2025 at 9:59 AM, R4 was sitting in his wheelchair in his room. R4's left leg was amputated below the knee. R4's right foot and lower leg was wrapped with rolled gauze. No drainage or odor was observed on R4's dressing. R4 said when he was first admitted to the facility, they missed a couple dressing changes. R4 said the nurses change his dressing every morning now. R4 said the dressing had already been changed at 6:30 AM. R4 said he goes to (a local wound clinic) once a week on Mondays. "The doctor said I am making steady progress in healing, especially with my circulatory issues." R4 said since he was admitted to the facility, he has not had any infection or decline in his wound. R4 said he is not sure if the nurses do an assessment of the wound or not. No nurse at the facility has measured it that he is aware of. Sometimes his wound does have drainage, that is why it is wrapped, and he has a boot on his foot. R4 said his wound doctor at the wound clinic said he is pleased with the progress so far considering all R4's circulation issues. R4 said the wound doctor thinks something else may be going on and has ordered a nuclear test be done. R4 said he also has anemia, diabetes, and other issues. R4 said he had the amputations prior to admission. "I came to the facility because I could not take care of the wounds. They were very bad."<br><br>On 7/11/2025, R4's wound assessments from 6/1/2025 through the present were requested from V3. V3 (Wound Nurse) said he did not do weekly assessments on R4 due to R4 going out to the wound clinic for wound care. V3 said the facility nurses change R4's dressing daily as ordered; however, weekly wound assessments are done at the wound clinic. V3 said he gets the information from the wound clinic notes, and uses the information from the wound clinic to fill out the Skin Impairment/Wound Forms on R4. | S9999 | | |

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| S9999 | Continued from page 14<br><br>On 7/11/2025 at 1:54 PM, V3 said, "I will do measurements and wound assessments for the residents that use (contracted wound company that comes to the facility) when I do rounds with the wound doctor. If a resident is not seen by (the contracted wound company), and goes out for wound care, then we go by the measurements and assessments done by the outside wound clinics. There are 3 residents in the facility with wounds that go out for wound care. (R1), (R4) and (R5) are the residents that go out to wound clinics." At 2:48 PM, V3 said there was not a wound nurse when he first took the job, so he did not really receive any training on how to do the job. V3 said he is still learning things.<br><br>On 7/15/2025 at 10:00 AM, V3 said, "Initially, (R1) was being seen by (contracted wound company) that comes to the facility. (R1) was referred to (a local wound clinic) around the end of April/beginning of May. She had a doppler scan and other tests and was referred to the wound clinic." V3 said, "The only trainingI received for the wound nurse position was about 4 hours of training when I took the job. Mostly on paper and laptop. A regional consultant provided some guidance." V3 was asked if he had any specific wound training or certification prior to taking the Wound Nurse position. V3 said he had been a nurse for 20 yrs. Other than that, he said he has not had any specific wound training or certification.<br><br>V3 provided Skin Impairment/Wound Forms for R4, dated 6/23/2025, 7/1/2025, and 7/8/2025. V3 said he filled out the forms with the information provided by the local wound clinic. V3 also provided wound clinic notes for R4, dated 6/30/2025, 7/7/2025, and 7/14/2025, as well as R4's initial admission assessment form for the local wound clinic. The only other assessment V3 provided was dated 6/12/2025; V3 did assess R4's wound and documented a partial assessment (No measurements. Just the wound bed characteristics).<br><br>The facility's September 2024 policy and procedure titled Skin Assessment showed. "1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. The policy showed documentation and Completion of Skin Assessment: A. Include date and time of the assessment, your name and position title. B. Document observations (e.g. skin conditions, how the resident tolerated the procedure, | S9999 | | |

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| S9999 | Continued from page 15<br>etc.). C. Document type of wound. D. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). E. Document if resident refused assessment and why. F. Document other information as indicated or appropriate."<br><br>(A) | S9999 | | |