STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE , NASHVILLE, Illinois, 62263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2546078/IL195752	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)5) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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 2 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. These requirements were not met as evidenced by: Based on observation, record review, and interview, the facility failed to timely identify, assess and monitor, and provide treatment to prevent the worsening of pressure ulcers for 1 of 3 residents (R2) reviewed for pressure ulcers in a sample of 3. This failure resulted in R2 developing two unstageable pressure ulcers requiring debridement at the bedside and being started on an antibiotic treatment related to pressure ulcer infection. Findings include: On 07/09/25 at 10:50 AM, V7, Licensed Practical Nurse (LPN) did R2's dressing change at this time. R2's old dressing was removed from the left (Lt.) buttock/ischium with a moderate amount of bloody drainage noted to the old bandage. Wound bed was red/granular, and the wound was 5 centimeters (cm) x by 6cm. No odor or signs of infection noted. Old dressing removed from the right (Rt.) buttock/ischium with a moderate amount of drainage noted. The wound measured 14cmx9cm with yellow/tan/eschar covering the wound bed. There was a foul odor noted when the dressing was removed. R2's Face Sheet, print date of 07/11/25, documented R2 was admitted to the facility on 05/15/23 and has diagnoses of but not limited to chronic kidney disease, stage 4 (severe), dependence on renal dialysis, morbid obesity, hypertension (HTN), Atrial Fibrillation, and Type II Diabetes Mellitus. R2's Minimum Data Set (MDS), dated 04/09/25, documented R2 is cognitively intact with a Brief Interview for	S9999		

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S9999	Continued from page 3 Mental Status (BIMS) of 14 out of 15, she independent with most of her activities of daily living (ADLs), and is frequently incontinent of bladder and always continent of bowel. MDS section M-skin dated 04/09/25, documented R2 did not have any pressure areas at this time, a formal assessment instrument/tool should be done, clinical assessment to be done, she is at risk for developing pressure ulcers/injuries, and she should have a pressure reducing device for her chair and her bed. R2's MDS- Ancillary Assessment, dated 04/09/25, documented R2's Braden Scale Assessment score was a 17= Mild Risk (9 or below=severe risk, 10-12=high risk, 13-14=moderate risk, and 15-18=mild risk). R2's MDS- Ancillary Assessment, dated 07/02/25, documented R2's Braden Scale Assessment score was 17. R2's last Braden Scale Assessment prior to the two above was completed on 06/05/23 with a score of 19. R2's Care Plan, admission date of 05/15/23, documented Potential for skin breakdown related to (r/t) incontinence, history (Hx) weeping lower extremities (L/E's), ace wraps for edema, morbid obesity, overactive bladder (OAB), Lt. Buttock stage 3, Rt. Buttock stage: unstageable (U). (An unstageable wound, specifically referring to a pressure ulcer, means the depth of tissue damage cannot be determined because the wound bed is obscured by slough (yellow, tan, tray, green, or brown) or eschar (tan, brown, or black). These are full-thickness injuries, but the extent of the damage below the surface cannot be seen.) Goal: R2 will develop no skin breakdown thru next review. Interventions include but are not limited to reposition self every two hours and as needed (PRN), monitor for redness or discoloration, and weekly skin checks. R2's Physician's Orders, dated 04/28/25 at 4:15 PM, documented skin check 6P-6A with showers on Monday, Wednesday & Friday. No redness, open areas, or excoriation at (@) present skin integrity = within normal limits (WNL) skin impairment = abnormal (ABN) every night shift every Mon, Wed, Fri for skin management. R2's Treatment Administration Record (TAR) for the month of May 2025 regarding weekly skin checks documented on 05/12/25 ABN. R2's Progress notes were reviewed for 05/12/25 and there was no documentation regarding R2's abnormal skin assessment. R2's Shower Sheet, dated 05/12/25, documented by V10,	S9999		

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S9999	Continued from page 4 Certified Nursing Assistant (CNA) found a small open area to the back of R2's left thigh. V6, Licensed Practical Nurse (LPN) signed off on the shower sheet. R2's Electronic Medical Record (EMR) was reviewed and there was no documentation on 5/12/25 noting if the nurse was notified of R2's opened area, the physician was notified of the new skin condition, no measurements or wound description, and no wound assessment or evaluation done. R2's TAR dated 05/26/25, documented R2's skin check for this day was WNL. R2's Shower Sheet, dated 05/26/25, documented V10, CNA noted redness and bleeding to R2's Rt. and Lt. back thigh area. V12, LPN signed off on the shower sheet. R2's EMR was reviewed and there was no documentation regarding the nurse being notified of the open areas to R2's bilateral thighs, the physician being notified, no wound measurements or wound description, and no wound assessment or evaluation done. On 05/28/25 R2's two shower sheets above were signed off by V5, Former Wound Nurse. R2's Progress Notes, dated 5/28/2025 at 2:35 PM, documented Skin/Wound Note, Note Text: while this writer was reviewing shower sheets, redness and bleeding was noted, this writer went to residents' room and talked with resident. Resident stated some discomfort to right and left under folds of coccyx, open areas noted to both right and left under folds of coccyx, contacted MD (Medical Director), MD gave order to apply cal (calcium) alg (alginate) cover with dry dressing. ETAR (electronic treatment administration record) updated at this time. R2's Physician's Orders, dated 05/28/25, documented Left under fold of coccyx and Right under fold of coccyx- Cleanse area with NS (Normal Saline) or WC (Wound Cleanser) apply Cal Alg cover with dry dressing until healed every night shift for wound and as needed (PRN). R2's TAR/weekly skin checks, for the month of June 2025 was reviewed and documented on 06/02/25, ABN skin check. There was no documentation in R2's EMR regarding the abnormal skin check. On 06/20/25, R2's TAR/weekly skin check had open written in the space provided and there was no documentation in R2's EMR regarding any skin issues. On 06/23/25, R2's TAR/weekly skin check documented the letter "o" in the space provided. There	S9999		

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S9999	Continued from page 5 was no progress notes noted regarding any skin issues. R2's TAR/weekly skin check for the date of 06/30/25, documented ABN and there were no progress notes regarding any abnormal skin findings. On 07/16/25 at 12:07 PM, V6, Infection Control Preventionist (ICP)/Wound Nurse stated if there is an abnormal finding on the weekly skin check there should be a progress note attached to it explaining why it is abnormal. R2's Progress Notes, dated 06/25/25 at 10:32 AM, documented MD gave order for resident to be evaluated by wound management. On 07/07/25 at 3:15 PM, This surveyor gave V1, Administrator a list of things that would be needed the next day. The wound care log for the past three months was one of the documents requested. On 07/08/25 at 8:35 AM, V2, Director of Nursing (DON) brought in wound care log for May and July 2025. She said the June log was jammed in the printer, and she would bring it as soon as she got it printed out. Wound care log dated 05/29/25, documented R2's wound measurements to her left buttock was 2x1x0.1 and was a stage 2. Right buttock measurements were 2.2x1.4x0.1 and was a stage 2. There was no wound care log for the month of June 2025 provided to this surveyor. R2's Physician's Orders, dated 07/01/25 at 11:19 AM, documented to contact wound management for evaluation and treatment. R2's Wound Assessment Report completed by V8, Wound Nurse Practitioner (NP), dated 07/01/25, documented R2's wound to her left buttock measured 8.0 centimeters (cm) x 4.0cm x 0.2cm and was a stage three pressure ulcer. R2's wound to her right buttock measured 14cm x 13cm and was unstageable. It also documented R2's wound to her right buttock had heavy purulent exudate (drainage that is thick, opaque, and tan, yellow, green, or brown in color is purulent. This is never a normal occurrence in the wound bed and is often associated with infection or high bacteria levels). Wound Care Education Institute. R2's Weekly Wound Assessment, dated 07/01/25, in R2's EMR documented onset date of 05/28/25, Lt. Buttock measurements 8.0x4.0x2.0 and the wound was unstageable. The Rt. buttock measurements for the wound were	S9999		

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S9999	Continued from page 6 14x13xUTD and the wound was unstageable. R2's Physician's Orders, dated 07/01/25, documented Left lower buttock/ischium and Right lower buttock/ischium- Cleanse area with NS or WC apply Silver Alginate, cover with silicone dressing. Change daily and PRN every night shift for wound. Wound care log dated 07/02/25, documented R2's wound measurements to her left buttock was 8x4x0.2 stage 2 and her right buttock measurements were 14x13x Unable to determine (UTD). R2's Weekly Wound Assessment, dated 07/08/25, documented R2's wounds were measuring Lt. Buttock: 8x5x0.2 and it was unstageable and the Right buttock: 14x13xUTD and was unstageable. R2's EMR was reviewed and there were no other weekly wound assessments done on the wounds to R2's Rt. and Lt. buttocks for the months of May 2025 and June 2025. R2's Progress Notes, dated 07/08/25 at 8:41 AM, documented R2 was seen by wound specialist (V8). R buttock has improved and measures 14x13xUTD. L buttock has declined and measures 8x5x0.2. Both wounds were debrided with a scalpel and forceps by V8. Awaiting final culture report on wounds. R2's wound culture that was collected on 07/02/25 documented R2 has Pseudomonas Aeruginosa in her wound. (This infection is a condition that can affect your skin, blood, lungs, GI tract and other parts of your body. Pseudomonas Aeruginosa bacteria are common in the environment, especially water, soil and produce. Symptoms vary according to where the infection is in your body. Treatment usually includes at least one type of antibiotic. A Pseudomonas Aeruginosa infection can be challenging to get rid of. It's rare for a Pseudomonas Aeruginosa infection to develop in people with a healthy immune system. But it can be serious and potentially deadly if you have a weakened immune system (immunocompromised). Common causes of weakened immune system include diabetes and kidney disease. Cleveland Clinic 2025). R2's Physician's Orders, dated 07/08/25 at 11:28 AM, documented Cipro Oral Tablet 250 milligrams (MG) (Ciprofloxacin HCl) Give 250mg by mouth two times a day for seven days for Skin management; Wound until 07/15/25. On 07/08/25 at 2:35 PM, V7, LPN said skin assessments are usually done on the resident's shower days. She	S9999		

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S9999	Continued from page 7 said the CNA will fill out the shower sheet and then the nurse will sign off on it. V7 said if she had someone with a new skin issue, she would contact the doctor and get an order for it until they can be seen by the wound nurse. She said if it an excoriation issue she will check her medication administration record (MAR) and see if they have some kind of cream ordered or if they have an anti-fungal powder ordered before contacting the doctor. She said if it was for an open wound, she would go down and assess the wound, do the initial measurements, call the doctor to get an order put into place, and then she would give it over to the wound nurse. She said the wound nurse would be the one to do all the measuring of the wounds after that and is also the one who makes rounds with wound Nurse Practitioner (NP). On 07/09/25 at 9:00 PM, V13, LPN said the last time she seen R2's wound was a long time ago. She said she usually works the other hallways, and it just so happened they put her down there that day. She thinks it was when the wounds first started but she can't remember. She said the wound on the left was smaller and the one on the right was much bigger and looked like a bruise, maybe there was an underlying wound or something but there was no open area and had no depth. She said she hasn't worked over there since and hasn't seen the wounds recently. On 07/09/25 at 9:10 PM, V10, CNA said she assisted R2 with her shower (05/12/25) and was drying her off when she noticed the towel had blood on it, so she looked and R2 had a small open area to her left buttock/thigh area. She said she always fills out the shower sheet and hands it to the nurse so she can review it. If there are any new skin issues, she lets the nurse know so they can go down and assess it and inform the wound nurse of any new wounds and that is what she did. V10 said she isn't sure if the nurse that night went down and assessed R2's wound or not. On 05/26/25 She said when she was drying off R2 and seen the blood on the towel she thought maybe the other side had opened. She said it was hard to remember because it was a while back. She said she would have done the same thing as she did for the other wound, she found on R2. V10 said she hasn't seen R2's wounds recently but she assisted R2 with her shower the day before yesterday (07/07/25) and the wounds had bandages on them, so she didn't get to see them. On 07/10/25 at 9:00 AM, V5, Former Wound Nurse said when there is a new skin issue found the CNAs are to document it on the shower sheets, the floor nurse is to assess the wound, notify the physician, get an order	S9999		

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S9999	Continued from page 8 for a treatment, and write it on the shower sheet. She said because of the floor nurses and agency nurses it's not being done. V5 said with R2 she was reviewing the shower sheets and seen R2's. She said she called the doctor and got an order put into place. V5 said she can't check the shower sheets every day. She said they could go weeks or however long without being checked. V5 said she was having to do her job and the floor nurses' job, and she just couldn't do it all. V5 said she informed V1, Administrator and V2, Director of Nursing (DON) and they didn't pay any attention to her, and nothing was done. V5 said she was sure things would have been different if there had been a treatment order done for R2 when it was first seen. On 07/08/25 at 12:16 PM, V8, Wound Nurse Practitioner (NP) said it depends on the facility's policy on how often skin assessments are to be done. She said they usually do them on the resident's shower days. V8 said they should be doing weekly assessments on everyone and on the residents who have wounds they should be doing a weekly wound report regardless of if they receive her services or not. On 07/10/25 at 8:55 AM, V8, NP/Wounds said she wasn't aware R2's wounds started on 05/12/25. She said R2's condition could have been different if they had a treatment put into place at that time. She said she would have had a better chance of healing and a better prognosis than now. V8 said R2 also has more of a chance of getting an infection. V8 said from 05/12/25 to 05/26/25 the wound had plenty of time to get worse. On 07/17/25 at 12:33 PM, V2, Director of Nursing, DON stated the CNAs are to do head to toe skin assessments twice a week with the resident's shower. If they find a new area or worsening area they are to report it to the nurse immediately. The nurses are to do assessments whenever they do a treatment, and the other skin checks come from the CNAs. V2 said if the CNA were to find a new area, she would expect the nurse to go down and look at it then contact the doctor or the wound nurse for further treatment. The facility's policy and procedure Prevention of Pressure Ulcers, not dated, documented Purpose: "The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors." It further documented General Guidelines: "2. The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. 3.	S9999		

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S9999	Continued from page 9 Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected." It also documented "5. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident." It further documented Interventions and Preventive Measures: General "9. Routinely assess and document the condition of the resident's skin per Weekly Skin Integrity form for any signs and symptoms of irritation or breakdown. 10. Report any signs of a developing pressure ulcer to the physician. 11. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate." It also documented Additional Factors that Indicate Residents at Risk: "The following are additional clinical conditions, treatments, and abnormal lab values that indicate that a resident is at risk for pressure ulcers: 1. Impaired/decreased mobility and decreased functional ability; 2. Co-morbid conditions, such as end stage renal disease, terminal cancer or diabetes mellitus. The facility's policy and procedure Resident Examination and Assessment, with a revised date of 02/2014, documented Purpose: "The purpose of the procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan." It further documented Physical Exam "8. Skin: a. intactness; b. moisture; c. color; d. texture; and e. presence of bruises, pressure sores, redness, edema, rashes." It also documented Documentation "The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data." It also documented Reporting "2. Notify the physician of any abnormalities such as, but not limited to e. wounds or rashes on the resident's skin; and f. worsening pain, as reported by the resident. 3. Report other information in accordance with facility policy and professional standards of practice." The facility's policy and procedure Pressure Ulcers/Skin Breakdown- Clinical Protocol, revised date of March 2014, documented "Assessment and Recognition 1. The nursing staff and Attending Physician will	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 10 assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue." The facility's policy Pressure Ulcer Risk Assessment, revised date of September 2013, documented Purpose "The purpose of the procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. Preparation 1. Review the resident's care plan to assess for any special needs of the resident. 2. Review current Braden Scale or facility risk assessment tool." It further documented General Guidelines "4. If pressure ulcers are not treated when discovered, they have the potential to become larger, painful and infected." It also documented "6. Once a pressure ulcer develops, it can be extremely difficult to heal." It further says "9. Pressure ulcers are a serious skin condition for the resident. 10. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation of breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. Assessment 1. Risk Assessment. A pressure ulcer risk assessment will be completed upon admission, quarterly, annually and with significant changes. 2. Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3. Monitoring: a. Staff will perform routine skin inspections (with daily care). b. Nurses are to be notified to inspect the skin if skin changes are identified. c. Nurses will conduct skin assessments at least weekly to identify changes." It further documented Identifying Residents at Risk "4. Diagnoses and Conditions that increase risk for pressure ulcers: f. Chronic or end stage renal, liver, or heart disease, g. Diabetes." It also documented "Documentation The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment conducted (for example, Admission Assessment, Weekly Skin Integrity tool.) 2. The date and time and type of skin care provided, if appropriate. 3. The name and title (or initials) of the individual who conducted the assessment. 4. Any changes in the resident's skin (i.e., the size and location of any red or tender areas), if identified." It also documented "12. Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2025

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S9999	Continued from page 11 alteration noted. 13. Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care if indicated." "B"	S9999		