STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058214	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Danville	**620 WARRINGTON AVENUE , DANVILLE, Illinois, 61832**

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S0000	Initial Comments Complaint Investigation: 2568952/2619464	S0000		
S9999	Final Observations Statement Of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)1)2)3)4)5)6)A) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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

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S9999	Continued from page 1 assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. These regulations were not met as evidenced by: Failures at this level require two separate deficient	S9999		

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S9999	Continued from page 2 practice statements. A. Based on observation, interview and record review the facility failed to reposition a resident timely, prevent cross contamination during wound care, provide the correct wound treatment, complete skin assessments timely, update a resident's care plan with pressure sore interventions, provide wound supplements, obtain ordered laboratory tests timely, and implement care plan interventions for pressure sore care and prevention for one (R4) resident of five residents reviewed for pressure sores. These failures resulted in R4 obtaining 18 separate facility acquired Pressure Sores from January 2025 through September 2025. R4 currently has five facility acquired Stage 4 Pressure Sores and two facility acquired Stage 2 Pressure Sores. B. Based on observation, interview and record review the facility failed to provide a timely initial assessment of R2's Left Ischium Stage 4 Pressure Ulcer, failed to identify R2's Coccyx Stage 2 Pressure Ulcer, failed to transcribe and provide physician ordered wound supplements and dressing changes and failed to prevent cross contamination during pressure ulcer care. The facility failed to update resident care plans with wound interventions and failed to prevent infections for R2 and R4. R2 obtained a Left Ischium Stage 4 Pressure Ulcer and a Coccyx Stage 2 Pressure ulcer at the facility. R2's Left Ischium Stage 4 facility acquired infected Pressure Ulcer and R13's Right Great Toe Stage 4 facility acquired Pressure Ulcer requires Antibiotic treatment and Contact Isolation. These failures affect two of five residents reviewed for Pressure Ulcers in a sample list of 14 residents. Findings include: A. R4's Electronic Medical Record (EMR) documents R4's medical diagnoses as fusion of the spine—lumbar region, spondylolisthesis, Parkinson's disease without dyskinesia, hypokalemia, anemia, vascular dementia, Escherichia coli, methicillin-susceptible Staphylococcus aureus infection, disorders of muscle, dysphagia—oropharyngeal phase, difficulty in walking, abnormal posture, reduced mobility, and pressure ulcers of the right buttock, left hip, sacrum, and left ankle. R4's Minimum Data Set (MDS), dated 9/2/25, documents R4 as severely cognitively impaired. This same MDS notes R4 as being completely dependent on staff for assistance with eating, oral hygiene, toileting, dressing, personal hygiene, and bed mobility.	S9999		

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S9999	Continued from page 3 R4's Care Plan intervention, dated 11/23/2024, instructs staff to complete weekly treatment documentation including measurements of each area of skin breakdown's width, length, depth, type of tissue, exudate, and any other notable changes or observations. This same Care Plan, initiated 11/19/2024, does not include a focus area, goal, nor interventions due to R4 being placed on contact isolation for his wound infection. It also does not include R4's Stage 4 sacral pressure ulcer; Stage 4 left lateral ankle pressure ulcer; Stage 4 right upper shin pressure ulcer; Stage 4 left lower medial knee pressure ulcer; or Stage 2 left inner buttock and right hip pressure ulcers. R4's Care Plan intervention dated 2/27/25 instructs staff to follow facility policies and protocols for the prevention and treatment of skin breakdown. R4's Pressure Ulcer Risk Assessment, dated 8/28/25, documents R4 as being at high risk for developing a pressure ulcer. R4's tasks do not include a turning schedule. R4's Pressure Report, dated 7/25/25, documents a facility-acquired left inner buttock Stage 2 pressure ulcer measuring 1.5 centimeters (cm) long by 0.8 cm wide with non-measurable depth. R4's Skin Condition Report, dated 8/19/25, documents a newly acquired coccyx pressure ulcer. This same report does not document the size, drainage, redness, signs of infection, and/or odor of R4's coccyx pressure ulcer. R4's Skin Condition Report, dated 8/27/25, documents a Stage 2 left inner buttock pressure ulcer. This same report does not document the size, drainage, redness, signs of infection, and/or odor of R4's left inner buttock pressure ulcer. R4's Physician Order Sheet (POS), dated September 2025, documents physician orders as follows:7/25/25: For R4's left inner buttock Stage 2 facility-acquired pressure ulcer—cleanse the wound, apply skin protectant, and cover with hydrocolloid dressing daily and as needed.9/12/25: Reposition R4 frequently while in bed.9/12/25: Meropenem intravenous solution reconstituted 1 GM every eight hours for twelve days, related to an unstageable sacral pressure ulcer. The same POS also documents an order to administer sulfamethoxazole-trimethoprim oral tablet 800-160 mg twice daily, related to Escherichia coli as the cause of methicillin-susceptible Staphylococcus aureus (MSSA) infection, for 11 days.9/13/25: Right hip Stage 2 pressure ulcer—cleanse with wound cleanser and apply	S9999		

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S9999	Continued from page 4 skin prep covering in silicone border dressing daily and as needed.9/18/25: Contact precautions for methicillin-resistant Staphylococcus aureus (MRSA).9/20/25: Right hip Stage 2 pressure ulcer—cleanse with wound cleanser and gauze, apply skin protectant to periwound area, cover wound with oil emulsion sheet cut to size, cover with silicone bordered foam, three times per week and as needed.9/20/25: Sacral Stage 4 pressure ulcer—cleanse with wound cleanser and gauze, pack wound with gauze soaked in quarter-strength Dakin's solution, cover with absorbent pad, and secure with retention tape twice daily and as needed.9/20/25: Left medial lower knee/leg—cleanse with wound cleanser and gauze, apply oil emulsion dressing to wound bed, then cover with gauze soaked with quarter-strength Dakin's solution. Cover with absorbent pad and secure with retention tape twice daily and as needed.9/20/25: Right upper shin Stage 4 pressure ulcer—cleanse with wound cleanser and gauze, apply oil emulsion then gauze soaked with quarter-strength Dakin's solution to wound bed, cover with absorbent pad, wrap with roll gauze, and secure with tape twice daily and as needed.9/20/25: Left lateral ankle Stage 4 pressure ulcer—cleanse with wound cleanser and gauze, apply oil emulsion then gauze soaked with quarter-strength Dakin's solution to wound bed, cover with absorbent pad, wrap with roll gauze, and secure with tape twice daily and as needed.9/20/25: Right ischium Stage 4 pressure ulcer—cleanse with wound cleanser and gauze, pack wound with iodoform packing strip, cover with absorbent pad, and secure with tape twice daily and as needed.9/20/25: Start Vitamin C 500 milligrams (mg) twice daily.9/21/25: Start Zinc 220 milligrams (mg) daily.9/22/25: Obtain a prealbumin level.R4's Hospital Record, dated 9/2/25–9/12/25, documents R4's chief complaint as an infected sacral decubitus wound and infected left lateral malleolus ankle wound. This same record documents that R4 underwent excisional debridement of his infected sacral decubitus and left ankle wounds. The record also documents that R4 was treated for sepsis due to an infected decubitus ulcer. R4's Laboratory Results for wound culture, reported on 9/5/25, document R4 has >100,000 colony-forming units (CFU)/milliliter (ml) of Proteus mirabilis. R4's Nurse Progress Note dated 9/2/25 at 3:10 PM documents: "(R4) is warm to touch, temperature 100.1 degrees Fahrenheit after ibuprofen and acetaminophen administered. Blood pressure (B/P) 92/58, pulse 99, oxygen saturation 98% on room air. Void test negative; strong odor coming from wound as well as increased drainage. (V21) Nurse Practitioner advised (V13) Wound	S9999		

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S9999	Continued from page 5 Physician will be rounding this afternoon and will assess." R4's Nurse Progress Note dated 9/2/25 at 5:44 PM documents V13 Wound Physician debrided and obtained a culture of R4's sacral pressure ulcer. This same note documents: "Infection confirmed, orders received to send (R4) out for possible sepsis due to wound infection." R4's Wound Management and Summary Evaluation progress notes dated 9/17/25 document a physician order for Zinc 220 mg daily, Vitamin C 500 mg twice daily, and to obtain a prealbumin level. R4's Laboratory Report dated 9/22/25 documents an albumin level of 3.0 grams (g)/deciliter (dl) with a normal range of 3.3–5.0 g/dl. This same laboratory report does not document a prealbumin level. On 9/20/25, from 10:05 AM to 2:45 PM, R4 was in his bed in his room. R4 was not repositioned or provided incontinence care during this timeframe. On 9/20/25 at 2:45 PM, R4's room door had a sign posted that read "Contact Isolation." Personal protective equipment (PPE) supplies were hanging from R4's door, including masks, gowns, and gloves. On 9/20/25 at 2:50 PM, V9 Licensed Practical Nurse (LPN) and V10 Registered Nurse (RN) completed pressure ulcer care for R4's sacrum, right ischium, right buttock, left inner buttock, and right hip. V9 LPN did not cleanse nor apply a new dressing to R4's right hip nor left inner buttock. V9 LPN removed R4's sacral dressing that was saturated with yellow drainage. V9 LPN was standing in front of the room air conditioner that was blowing air, which caused V9's PPE gown to make contact twice with R4's sacrum Stage 4 pressure ulcer. V9 LPN used her left gloved hand to push her gown off of R4's sacral pressure ulcer and then continued to complete R4's wound dressing change without washing her hands or changing gloves. V10 RN assisted in holding R4 onto his left side during wound care. V10 RN released her hold on R4, which caused R4's sacral Stage 4 pressure ulcer to touch his contaminated incontinence brief. V9 LPN applied R4's sacral dressing without cleansing R4's sacral Stage 4 pressure ulcer after the wound made contact with the incontinence brief and prior to applying a new dressing. On 9/20/25 at 3:45 PM, V9 LPN stated she knew that her gown had made contact with R4's sacral Stage 4 pressure ulcer. V9 LPN stated she should have changed her gown	S9999		

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S9999	Continued from page 6 and re-cleansed R4's sacral wound prior to applying a clean dressing. V9 LPN stated she had reviewed all of the orders prior to completing the wound dressing changes but said, "there are so many, it is confusing." V9 LPN stated cross-contaminating R4's open pressure ulcers could cause an infection or worsen his current wound infection. On 9/21/25 at 10:30 AM, V2 Director of Nurses (DON) stated R4 has "multiple" facility-acquired pressure ulcers. V2 DON stated R4 has had an overall decline in his mobility over the last several months. V2 DON stated the facility should have provided complete wound care, which would involve full assessments, obtaining and following physician orders for wound care, and ensuring pressure ulcer interventions are being followed. V2 DON stated R4 is considered a long-term resident who is unable to care for himself and relies wholly on staff for all care. V2 DON stated V13 Wound Physician sees R4 weekly. V2 DON stated the facility does not always send a nurse to round with V13 Wound Physician. V2 DON stated the facility floor nurses are expected to review V13's wound progress notes for their assigned residents prior to providing wound care. V2 DON stated V13's wound progress notes are located in the miscellaneous tab and are not added to the Physician Order Sheet (POS) until V14 RN completes her review of all resident wounds on Wednesdays. On 9/21/25 at 12:00 PM, R4 was not served double portions of protein as ordered by the physician. On 9/22/25 at 11:50 AM, V14 Registered Nurse (RN)/Float Nurse stated the role of the float nurse is to take an assigned group of residents for the first half of the shift, provide all treatments for all residents, and assist R4 in eating for two meals of the day. V14 RN stated she is not the wound nurse and is not in charge of the wound program but frequently completes wound care for all residents. V14 RN stated R4's sacrum Stage 4 pressure ulcer has declined significantly. V14 stated when she first assessed R4's sacral pressure ulcer, it was "smaller than my fingertip with no drainage or infection." V14 RN stated V13 Wound Physician couldn't make it on 9/16 but did round on 9/17/25. V14 RN stated she was not able to round with V13 Wound Physician that day and is not aware of any new orders. V14 RN stated the floor nurses do not look in the miscellaneous tab and search through pages of wound progress notes. V14 RN stated the floor nurses should follow what the POS has listed for wound care for any given resident. V14 RN stated she is not sure why R4's left inner buttock has not been assessed from 7/25/25 to 9/12/25. V14 RN stated she assessed R4 when he returned from the	S9999		

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S9999	Continued from page 7 hospital on 9/12/25 and observed R4's sacral Stage 4 pressure ulcer, right ischium Stage 4 pressure ulcer, right hip Stage 2 pressure ulcer, left inner buttock Stage 2 pressure ulcer, and two separate Stage 2 pressure ulcers on R4's right buttock, in addition to other wounds on R4's right and left lower legs and left foot. V14 RN stated she documented all of these wounds on R4's readmission assessment from his return from the hospital but did not complete full assessments of each wound. On 9/24/25 at 12:15 PM, V20 (R4's Power of Attorney [POA]) stated R4 was admitted to the facility in November 2024 and was still walking in January 2025. V20 stated the facility let R4 walk all day and "never changed" (provided incontinence care) for R4, which caused his first pressure ulcer on R4's right ischium in January 2025. V20 stated R4 has had multiple facility-acquired pressure ulcers since January 2025, all caused by facility staff not turning and positioning R4 timely. V20 stated R4's condition declined due to his Parkinson's disease, but the facility "should have been paying closer attention" to R4. V20 stated R4 requires "good" skin care that he is not receiving. V20 stated she visits R4 daily and sees every day that the staff wait three to four hours before coming into R4's room to reposition him or to check if he is incontinent. V20 stated V13 Wound Physician had to "cut all the dead skin" off R4's sacral wound on 9/2/25, and the hospital then took R4 into surgery to remove the rest. V20 stated R4's sacral wound "smelled horrible from outside the room." On 9/24/25 at 2:00 PM, V14 Float Nurse stated R4's wound round report dated 9/17/25 documents R4's left buttock pressure ulcer as being present on admission. V14 stated R4's left buttock pressure ulcer should have been labeled left inner buttock and facility-acquired. V14 LPN stated this was a documentation error on her part and should be corrected. On 9/30/25 at 2:45 PM, V13 Wound Physician stated the facility is expected to follow V13's orders for wound care the day the order is received. V13 stated he sees residents at this facility without any staff assistance and then writes the progress notes, which get uploaded early the next day. V13 Wound Physician stated he was under the impression that V2 Director of Nurses (DON) was reviewing and entering his wound orders into the Electronic Medical Record (EMR) the same day as they are uploaded. V13 stated it is not acceptable for the facility to wait two, three, or four days for changes in wound orders to be entered. V13 Wound Physician stated R4 is very compromised by all of his pressure	S9999		

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S9999	Continued from page 8 ulcers. He stated R4 has had a total of 18 facility-acquired pressure ulcers since “the beginning of the year.” V13 stated R4 has had several pressure ulcers resolve, which shows R4 has the potential to heal his wounds. V13 stated the facility “lags behind” in getting the interventions and orders in place, and then when the facility “finally catches up,” the resident’s wounds begin to heal. V13 stated this lag shows that the facility is not doing their job and that it takes a “negative toll” on the residents affected. B. 1. R2’s undated Face Sheet documents that R2 was admitted to the facility on 6/2/2024. R2's undated Medical Diagnosis list documents R2's medical diagnoses as Parkinson's Disease without dyskinesia, moderate protein-calorie malnutrition, anemia, dementia, Stage 4 pressure ulcer of the left buttock, and lack of coordination. R2's Minimum Data Set (MDS) dated 9/4/25 documents R2 as severely cognitively impaired. This same MDS documents that R2 is dependent on staff for total assistance with oral hygiene, toileting, dressing, personal hygiene, and requires maximum assistance from staff for bathing and transfers. R2's Care Plan intervention dated 7/01/25 instructs staff to provide supplemental protein, amino acids, vitamins, and minerals as ordered to promote wound healing. R2’s Care Plan does not include a focus area, goal, or interventions for R2’s left ischium Stage 4 pressure ulcer or R2’s coccyx Stage 2 pressure ulcer. R2's Electronic Medical Record (EMR) repositioning task documentation dated 8/22/25 through 9/21/25 documents that R2 was repositioned in bed two times on 9/20/25. There are no other entries recorded for R2 being repositioned. R2's EMR documents that V15 CNA recorded redness on R2's left lower buttock on 8/29/25 at 10:58 PM. R2's Nurse Progress Notes dated 9/1/2025 at 4:22 PM document that staff notified R10, a Registered Nurse (RN), that R2 had an open area on her buttocks. The same note documents an open area measuring 2.0 cm long by 2.0 cm wide on R2's left gluteal fold and a treatment order received for skin prep, calcium alginate, and a foam dressing to be applied daily. R2's Physician Order Sheet (POS) dated September 2025 documents the following physician orders:Starting 9/3/25 and ending 9/20/25 for R2's left gluteal fold (later labeled as left ischium): Cleanse with wound cleanser and gauze, apply skin prep to periwound, then	S9999		

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S9999	Continued from page 9 apply calcium alginate and bordered foam dressing daily on Tuesday, Thursday, Saturday, and as needed.9/20/25 for Vitamin C 500 mg twice daily for wound care, with no end date.9/20/25, with no end date, for R2's left ischium Stage 4 pressure ulcer: Cleanse with wound cleanser and gauze, pack wound with woven gauze soaked with 1/4 strength Dakin's solution, cover with absorbent pad and secure with retention tape twice daily and as needed.9/21/25 for Zinc 220 mg daily for wound care through 10/5/25.9/21/25 for Contact Isolation Precautions for wound infection.9/21/25 to administer Levofloxacin oral tablet 500 mg daily for a wound infection through 10/5/25.9/30/25–10/14/25: administer Linezolid (antibiotic) 600 mg twice daily for R13's Stage 4 pressure ulcer.R2's Laboratory Results Report, as reported to the facility on 9/19/25, documents that R2's wound culture resulted in >100,000 colony-forming units (CFU)/ml of Escherichia coli (E. coli), Extended Spectrum Beta-Lactamase (ESBL), and Enterococcus faecalis. R2's Wound Evaluation and Management Summary dated 9/2/25 documents an initial visit to assess an unstageable pressure injury/deep tissue injury (DTI) of the left ischium. The same summary documents moderate serous drainage with purple/maroon discoloration, no signs of infection, and wound measurements of 2.0 cm long by 1.5 cm wide with undetermined depth. The Wound Summary dated 9/17/25 documents the left ischium pressure ulcer as a Stage 4 ulcer (post-surgical debridement), with moderate serous drainage, 100% thick adherent devitalized necrotic tissue, measuring 3.0 cm x 3.0 cm, with unmeasurable depth due to nonviable tissue and necrosis. A wound culture was obtained. Physician orders documented in the same summary include:Cleanse the wound, pack with gauze soaked in ¼ strength Dakin's solution, and cover with absorbent dressing twice daily and as needed.Vitamin C 500 mg twice daily, Zinc 220 mg daily for 14 days, and obtain a pre-albumin level starting 9/17/25.On 9/20/25, from 10:30 AM to 1:50 PM, R2 was sitting upright in a reclining wheelchair in the resident common area. R2 was not repositioned or provided incontinence care during this time. At 1:55 PM, CNAs V7 and V11 assisted R2 to bed. CNA V7 stated that R2 had not been repositioned or provided incontinence care since being assisted out of bed before lunch at 10:15 AM. At 2:00 PM, RN V8 and LPN V9 provided wound care for R2's Stage 4 pressure ulcer on the left ischium. The wound had a golf ball-sized opening with moderate serous drainage and white and grey soft adherent	S9999		

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S9999	Continued from page 10 tissue. The open wound emitted a foul odor that became more pungent as the dressing was removed. V8 RN's right forefinger fit into the wound while cleansing it. V8 RN applied calcium alginate and a dry dressing, but did not use gauze soaked in ¼ strength Dakin's solution. R2 also had a 1 cm open, red area on her coccyx. V8 RN identified it as a Stage 2 pressure ulcer and said this was the first time they were aware of the coccyx wound. RN V8 and LPN V9 completed wound care without measuring or dressing the coccyx Stage 2 ulcer. LPN V9 described the ischium wound as smelling "terrible" in the morning and "even worse" during the dressing change. On 9/22/25 at 2:30 PM, CNA V15 stated she found a new reddened area on R2's left lower buttock on 8/29/25. She said it was closed, dark red with even darker red spots in the center. V15 CNA reported it to RN V10, who applied a "brown foam patch" that night. V15 stated the patch remained for "a couple of days" and then the area was not covered at all for several days. On 9/22/25 at 11:45 AM, Float RN V14 stated she had seen R2's ischium wound when it was still closed and again on 9/17/25. She noted significant deterioration. V14 RN emphasized that R2 is severely cognitively impaired and fully dependent on staff for turning, bed mobility, and toileting. On 9/23/25 at 2:15 PM, DON V2 stated that any time a resident develops a new pressure ulcer, a risk management assessment should be initiated. The wound should be fully assessed, including measurements, odor, drainage, and signs of infection. V2 DON stated that R2's coccyx Stage 2 ulcer should have been identified during incontinence care, skin checks, or showers. She confirmed that the Stage 4 ischium ulcer was acquired in-house and became infected during R2's stay. V2 DON acknowledged that the facility caused both the ulcer and the resulting infection. 2. R13's undated Face Sheet documents that R13 was admitted to the facility on 11/25/2024. R13's Electronic Medical Record (EMR) lists diagnoses including chronic systolic heart failure, atrial fibrillation, anemia in chronic kidney disease, acute respiratory failure with hypoxia, dysphagia, unsteadiness on feet, reduced mobility, and disorders of the lung. R13's Minimum Data Set (MDS) dated 7/4/2025 documents R13 as moderately cognitively impaired. The same MDS shows R13 requires maximum assistance from staff for toileting, upper and lower body dressing, putting on	S9999		

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S9999	Continued from page 11 and taking off footwear, personal hygiene, and bed mobility. R13 is completely dependent on staff for transfers and bathing. R13's Physician Order Sheet (POS) dated September 2025 documents a physician order dated 9/20/25 for wound care for a Stage 4 pressure wound of the right, distal, medial foot:Cleanse with wound cleanser and gauze.Apply gauze soaked in ¼ strength Dakin's solution.Fill wound cavity with collagen powder.Cover with absorbent pad (cut to size) and wrap with roll gauze twice daily and as needed.The same POS includes a physician order starting 9/26/25 through 10/4/25 to administer Linezolid (antibiotic) 600 mg twice daily for R13's Stage 4 pressure ulcer. R13's Wound Evaluation and Management Summary - Initial Evaluation dated 4/1/25 documents the Stage 4 pressure ulcer on the right, distal, medial foot as having 30% thick adherent devitalized tissue, moderate serous drainage, and measuring 1.3 cm long by 1.0 cm wide by 0.2 cm deep. A subsequent Wound Evaluation and Management Summary dated 9/17/25 documents the same ulcer as exacerbated due to infection and measuring 0.7 cm long by 1.0 cm wide by 0.5 cm deep, with signs of infection. Another Wound Evaluation and Management Summary, dated 9/24/25, documents that a wound culture was obtained via deep swab on 9/17/25 and the results revealed Methicillin-Resistant Staphylococcus Aureus (MRSA). On 9/30/25 at 3:00 PM, V13 (Wound Physician) and V23 (Registered Nurse) completed wound care for R13's right medial great toe Stage 4 pressure ulcer. RN V23 did not change gloves or perform hand hygiene after removing R13's dressing and prior to applying a clean dressing. The old dressing was adhered to the wound, requiring V23 to soak it off with normal saline. The ulcer appeared dime-sized with a thick, dry, yellow slough covering it before V13 debrided the wound, revealing a red wound bed. At 3:20 PM on the same day, RN V23 admitted she forgot to change gloves or perform hand hygiene between removing and reapplying the dressing. At 2:55 PM on 9/30/25, Wound Physician V13 stated that R13's right medial great toe Stage 4 pressure ulcer was caused by the inside of R13's shoe, which had overlapping material that rubbed against the toe. V13 stated that they had cut a hole in the side of R13's	S9999		

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S9999	Continued from page 12 shoe to relieve pressure "months ago." On 10/1/25 at 2:00 PM, DON V2 stated that facility nurses are expected to change gloves and perform hand hygiene after removing a soiled dressing and prior to applying a new one. V2 DON stated she was not in her role at the time R13 developed the pressure ulcer and therefore could not speak to how it was acquired. She also confirmed that a risk management assessment was not completed for R13's ulcer. V2 DON stated that cross-contaminating an open pressure ulcer can allow bacteria to enter the wound and cause an infection. She confirmed that R13's infected Stage 4 pressure ulcer on the right great toe was facility-acquired and could have been prevented. On 9/26/25 at 11:00 AM, Nurse Practitioner (NP) V21 stated that both R2 and R4 are completely dependent on staff for all care and are severely cognitively impaired. V21 NP stated that the facility should, at minimum:Turn, reposition, and provide incontinence care at least every two hours.Provide proper nutrition.Complete thorough admission assessments.Conduct weekly skin assessments, as required by facility protocol.V21 NP stated that the facility did cause R4's multiple pressure ulcers by not providing the full care required. V21 NP emphasized that cross-contamination of any wound can result in infection and that handwashing is the cornerstone of infection prevention, helping break the infection chain from source to person. V21 NP also stated that once the facility becomes aware of new pressure ulcers, a whole-house baseline skin assessment should be completed. Due to R4's extensive facility-acquired pressure ulcers, V21 NP said, "that is reason enough to believe the facility is lacking in their care of this resident." V21 NP stated the first priority is to halt the worsening of R4's pressure ulcers, and then to focus on identifying and properly assessing any new facility-acquired wounds. Incomplete or inaccurate wound assessments result in suffering for the resident due to insufficient care. V21 NP emphasized that the facility must: Identify dependent residents, focus on preventing worsening of pressure ulcers, acknowledge and address new wounds in a timely manner, ensure all physician orders are promptly added to the Physician Order Sheet (POS) to ensure continuity of care, understand that failure to provide prescribed treatment can worsen pressure	S9999		

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S9999	Continued from page 13 ulcers, and implement a “warm hand-off” procedure, meaning staff should briefly meet with providers during rounds to obtain any new physician orders or treatment changes. The facility policy titled Pressure Ulcer Prevention, reviewed on January 15, 2018, states turn dependent residents approximately every two hours, or more frequently as needed, position residents using pillows or pads to protect bony prominences, if redness does not disappear within 30 minutes, the turning schedule should be shortened to every hour, inspect the skin several times daily during bathing, hygiene, and repositioning, and keep bottom sheets dry, tightly stretched, and free of wrinkles. (A)	S9999		