STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057505	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR , GODFREY, Illinois, 62035

(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 Annual Health Survey	S0000		08/21/2025
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.1210 d)1) 300.1210 d)2) 300.1210 d)5) 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	S9999		08/21/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057505	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

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S9999	Continued from page 1 or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210. General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 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 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. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor wound treatments and implement wound treatment per physician's orders for 3	S9999		

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S9999	Continued from page 2 of 3 residents (R52, R22, and R19) reviewed for wounds in the sample of 38. This failure resulted in R52's left diabetic foot ulcer (DFU) worsening on 5/19/25, requiring extensive hospitalization, including an ICU (intensive care unit) stay, for a total of 40 days 6/10/25-6/18/25 and 6/23/25-7/24/25 for sepsis and also osteomyelitis to R52's left diabetic foot ulcer. R52 required IV (intravenous) antibiotics, PICC (peripherally inserted central catheter) line insertion and surgical debridement. Findings include: 1.R52's Face Sheet documented he was originally admitted to the facility on 1/12/23, and newly admitted on 7/24/25 with diagnoses of central cord syndrome, methicillin resistant staphylococcus aureus (MRSA) infection, type two diabetes mellitus with foot ulcer, acute osteomyelitis left ankle and foot, and sepsis. R52's Minimum Data Set (MDS), dated 6/22/25, documented he was cognitively intact, is dependent on staff for assistance with mobility, and has intravenous access through a midline. R52's Hospital Discharge Summary, dated 1/14/25, documented during his stay, podiatry and infectious disease were consulted for his wound and per podiatry, debridement took place on 1/10/25 with possible osteomyelitis along with an MRI (magnetic resonance imaging) suggestive of osteomyelitis. R52's Skin and Wound Note, dated 1/15/2025 at 6:52 PM, documented he was being seen for evaluation of a diabetic foot ulcer (DFU) to his left heel that was surgically debrided while in the hospital per patient. The wound note documented the status was improving despite measurements, and exposed tissues included epithelium, dermis, subcutaneous and bone; the exudate was a moderate amount of serosanguineous drainage. The wound note continued to document the size of his DFU on 1/15/25 was 1.5 cm (centimeters) x (by) 4.7 cm x 0.4 cm. R52's Skin and Wound Note, completed by contracted wound company providing weekly wound care at the facility, dated 2/5/25, documented his left DFU status was stable, exposed tissues of epithelium, dermis, subcutaneous, and bone; exudate was a moderate amount of serosanguineous drainage. The wound note documented treatment orders as follows: cleanse with wound cleanser, apply SSD (Silver sulfadiazine), Collagen Particles, Calcium alginate to base of the wound, secure with ABD (abdominal pad), rolled gauze, change	S9999		

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S9999	Continued from page 3 Daily, and PRN (as needed). The note documented the following procedure was completed as follows: surgical wound debridement to left heel with measurements of Pre-Debridement Measurement: 2.5 cm x 2.5 cm x 0.3 cm and Post-Debridement Measurement: 2.5cm x 2.5cm x 0.3cm, 100% of the wound was debrided with indications to remove biofilm causing delayed wound closure and stimulate acute healing, a topical Lidocaine anesthetic was used, adequate pain control was obtained, the potential benefits and risks included, but were not limited to scar formation, bleeding, and infection which were reviewed with R52 with consent on file. R52's Treatment Administration Record (TAR) and Physician orders documented on 2/5/25 orders remained as follows: cleanse left heel with wound cleanser, apply SSD, Hydrogel, Collagen, and Calcium alginate then cover with ABD and rolled gauze daily. R52's Wound Consultant's Skin and Wound Note, dated 2/12/25, documented R52's left DFU wound status was improving with delayed wound closure, a size of 3.5 cm x 1.5 cm x 0.2 cm, exposed tissues were epithelium, dermis, subcutaneous, and bone, exudate was a moderate amount of serosanguineous drainage. The wound note documented treatment orders as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, change Daily, and PRN. R52's TAR and Physician orders documented on 2/12/25 orders remained as follows: cleanse left heel with wound cleanser, apply SSD, Hydrogel, Collagen, and Calcium alginate then cover with ABD and rolled gauze daily. R52's Wound Consultant's Skin and Wound Note, dated 2/26/25, documented his left DFU wound status was improving with delayed wound closure, 20% of slough, exposed tissues: epithelium, dermis, subcutaneous, and bone; exudate was a moderate amount of serosanguineous drainage. The wound note documented treatment orders as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, change Daily, and PRN. The note documented the following procedure was completed as follows: surgical wound debridement to left heel with measurements of Pre-Debridement 3.5 cm x 1.5 cm x 0.2 cm and Post-Debridement Measurement: 2.5cm x 2cm x 0.3cm, 100% of the wound was debrided with indications to remove biofilm causing delayed wound closure and stimulate acute healing, a topical Lidocaine anesthetic was used, adequate pain control was obtained, the potential benefits and risks	S9999		

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S9999	Continued from page 4 included, but were not limited to scar formation, bleeding, and infection which were reviewed with R52 with consent on file. R52's TAR and Physician orders documented on 2/26/25 orders remained as follows: cleanse left heel with wound cleanser, apply SSD, Hydrogel, Collagen, and Calcium alginate then cover with ABD and rolled gauze daily. R52's Wound Consultant's Skin and Wound Note, dated 3/5/25, documented his left DFU wound status was improving with delayed wound closure, 10% slough, exposed tissues: epithelium, dermis, subcutaneous, and bone; exudate was a moderate amount of serosanguineous drainage. The wound note documented treatment orders as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, change Daily, and PRN. The note documented the following procedure was completed as follows: surgical wound debridement to left heel with measurements of Pre-Debridement 2 cm x 1 cm x 0.2 cm and Post-Debridement Measurement: 2cm x 1cm x 0.3cm, 100% of the wound was debrided with indications to remove biofilm causing delayed wound closure and stimulate acute healing, a topical Lidocaine anesthetic was used, adequate pain control was obtained, the potential benefits and risks included, but were not limited to scar formation, bleeding, and infection which were reviewed with R52 with consent on file. R52's TAR and Physician orders documented on 3/5/25 orders remained as follows: cleanse left heel with wound cleanser, apply SSD, Hydrogel, Collagen, and Calcium alginate then cover with ABD and rolled gauze daily. R52's Wound Consultant's Skin and Wound Note, dated 3/12/25, documented his left DFU wound status was improving with delayed wound closure with a size of 1.5 cm x 1 cm x 0.2 cm, 10% slough, exposed tissues: epithelium, dermis, subcutaneous, and bone; exudate was a moderate amount of serosanguineous drainage. The wound note documented treatment orders as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, change Daily, and PRN. R52's TAR and Physician orders documented on 3/12/25 orders remained as follows: cleanse left heel with wound cleanser, apply SSD, Hydrogel, Collagen, and Calcium alginate then cover with ABD and rolled gauze daily.	S9999		

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S9999	Continued from page 5 R52's TAR and Physician orders, dated 3/17/25, documented wound orders as follows: cleanse left heel with wound with cleanser, apply SSD, collagen particles, calcium alginate then apply ABD and rolled gauze daily and PRN. R52's Wound Consultant's Skin and Wound Note, dated 3/19/25, documented his left DFU wound status was stable, 10% slough, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a moderate amount of serosanguineous drainage. The wound note documented treatment orders as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, change Daily, and PRN. The note documented the following procedure was completed as follows: surgical wound debridement to left heel with measurements of Pre-Debridement Measurement: 2.5 cm x 3 cm x 0.2 cm and Post-Debridement Measurement: 2.5cm x 3cm x 0.3cm, 100% of the wound was debrided with indications to remove biofilm causing delayed wound closure and stimulate acute healing, a topical Lidocaine anesthetic was used, adequate pain control was obtained, the potential benefits and risks included, but were not limited to scar formation, bleeding, and infection which were reviewed with R52 with consent on file. R52's Wound Consultant Skin and Wound Note, dated 3/28/25, documented his left DFU wound status was improving with delayed wound closure with a size of 2 cm x 2.5 cm x 0.2 cm, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a moderate amount of serosanguineous drainage. The wound note documented treatment orders as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, change Daily, and PRN. R52's Hospital Discharge Summary, dated 4/1/25, documented wound orders for R52's left heel was as follows: clean with gentle soap/water daily, pat dry, apply Iodosorb gel to wound bed, then cover with 4x4, ABD, rolled gauze to be changed daily and PRN (as needed). R52's TAR and Physician's Orders, dated 4/1/25-4/7/25, documented no active wound care orders or treatment. The Hospital's Discharge summary wound orders were not initiated by the facility. R52's Wound Consultant's Skin and Wound Note, dated 4/7/25, documented his left DFU wound status was the first evaluation of existing wound by new provider with	S9999		

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S9999	Continued from page 6 a size of 1.7 cm x 0.9 cm x 0.5 cm and exudate was a moderate amount of serosanguineous drainage. The treatment orders were as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze and to change daily. R52's TAR and Physician's Ordersl dated 4/7/25-4/16/25, documented no active wound care orders or treatment. R52's Wound Consultant's Skin and Wound Notel dated 4/16/25, documented his left DFU wound status was improving without complications with a size of 1.3 cm x 0.7 cm x 0.5 cm, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a moderate amount of serosanguineous drainage. Treatment orders were as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, and change 3 times per week. R52's TAR and Physician's Orders dated 4/16/25-4/20/25, had no documentation the order from the Wound Consultant dated 4/16/25 was initiated. R52's TAR and Physician's Orders, dated 4/21/25, documented wound care orders for his left DFU as follows: cleanse with wound cleanser and pat dry, mix SSD cream, collagen particles and hydrogel together, apply thin layer to calcium alginate dressing and apply to left heel, cover with ABD pad, wrap with rolled gauze and secure with tape to be changed three times per week and PRN. R52's Wound Consultant's Skin and Wound Note, dated 4/23/25, documented his left DFU wound status was present on admission with a size of 1.1 cm x 0.7 cm x 0.5 cm, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a moderate amount of serosanguineous drainage. Treatment orders were as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, and change 3 times per week. R52's TAR and Physician's Orders, dated 4/23/25, documented wound care orders for his left DFU as follows: cleanse with wound cleanser and pat dry, mix SSD cream, collagen particles and hydrogel together, apply thin layer to calcium alginate dressing and apply to left heel, cover with ABD pad, wrap with rolled gauze and secure with tape to be changed three times per week and PRN.	S9999		

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S9999	Continued from page 7 R52's Wound Consultant's Skin and Wound Note, dated 4/30/25, documented his left DFU wound status was stable with a size of 1.5 cm x 0.8 cm x 0.3 cm, 25-49% slough, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a moderate amount of serosanguineous drainage. Treatment orders were as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, and change 3 times per week. R52's TAR and Physician's Orders, dated 4/30/25, documented wound care orders for his left DFU as follows: cleanse with wound cleanser and pat dry, mix SSD cream, collagen particles and hydrogel together, apply thin layer to calcium alginate dressing and apply to left heel, cover with ABD pad, wrap with rolled gauze and secure with tape to be changed three times per week and PRN. R52's Wound Consultant's Skin and Wound Note, dated 5/7/25, documented his left DFU wound status was stable, 25-49% slough, exposed tissues: epithelium, dermis, subcutaneous, exudate moderate amount of serosanguineous drainage. Treatment orders were as follows: cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with ABD, rolled gauze, and change 3 times per week. The note documented the following procedure was completed as follows: surgical wound debridement to left heel with measurements of Pre-Debridement Measurement: 1.5 x 0.8 x 0.3 cm and Post-Debridement Measurement: 1.5 x 0.8x 0.3, 100% of the wound was debrided with indications to remove biofilm causing delayed wound closure and stimulate acute healing, a topical Lidocaine anesthetic was used, adequate pain control was obtained, the potential benefits and risks included, but were not limited to scar formation, bleeding, and infection which were reviewed with R52 with consent on file. R52's TAR and Physician's Orders, dated 5/7/25, documented wound care orders for his left DFU as follows: cleanse with wound cleanser and pat dry, mix SSD cream, collagen particles and hydrogel together, apply thin layer to calcium alginate dressing and apply to left heel, cover with ABD pad, wrap with rolled gauze and secure with tape to be changed three times per week and PRN. R52's Wound Consultant's Skin and Wound Note, dated 5/14/25, documented his left DFU wound status was worsening with a size of 3.5 cm x 2.5 cm x 1 cm, 25-49% slough, exposed tissues: epithelium, dermis, and	S9999		

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S9999	Continued from page 8 subcutaneous; exudate was a moderate amount of serosanguineous drainage. Treatment orders were as follows cleanse with wound cleanser, apply SSD, Collagen Particles, Calcium alginate to base of the wound, secure with Superabsorbent, ABD, and rolled gauze to be changed daily, and PRN. R52's TAR and Physician's Orders, dated 5/15/25, documented wound care orders for his left DFU as follows: Cleanse left heel diabetic ulcer with wound cleanser and pat dry, mix SSD cream, collagen particles and hydrogel together, apply thin layer to calcium alginate dressing and apply to left heel, cover with ABD pad, wrap with rolled gauze and secure with tape to be changed three times per week and PRN. R52's Skin and Wound Note, dated 5/21/25, documented his left DFU wound status was worsening with a size of 5.5 cm x 18 cm x 1 cm, at 3 o'clock tunneling 3 cm, 25-49% slough, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a heavy amount of seropurulent drainage. Treatment orders were as follows: cleanse with wound cleanser, apply Dakins moistened fluffed gauze, Xeroform (gauze impregnated with a petrolatum blend) to lateral foot to base of the wound, secure with Superabsorbent, ABD, rolled gauze to be changed daily, and PRN. R52's TAR and Physician's Orders, dated 5/22/25, documented wound care orders for his left DFU as follows: cleanse with wound cleanser and pat dry, apply Dakins wet gauze place into wound and place gauze on top, cover with super absorbent pad, ABD and rolled gauze QD (every day) and prn. R52's Wound Consultant's Skin and Wound Note, dated 5/28/25, documented his left DFU wound status was improving without complications, 25-49% slough, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a heavy amount of seropurulent drainage. Treatment orders were as follows: cleanse with wound cleanser, apply Dakins moistened fluffed gauze to base of the wound, secure with Superabsorbent, ABD, and rolled gauze to be changed daily, and PRN. The note documented the following procedure was completed as follows: surgical wound debridement to left heel with measurements of Pre-Debridement Measurement: 7 cm x 7 cm x 1 cm and Post-Debridement Measurement: 7 cm x 7 cm x 1 cm, at 3 o'clock tunneling 3 cm, 100% of the wound was debrided with indications to remove biofilm causing delayed wound closure and stimulate acute healing, a topical Lidocaine anesthetic was used, adequate pain control was obtained, the potential benefits and risks included, but were not limited to scar formation,	S9999		

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S9999	Continued from page 9 bleeding, and infection which were reviewed with R52 with consent on file. R52's Wound Consultant's Skin and Wound Note, dated 6/4/25, documented during the evaluation for his left DFU a workup for osteomyelitis was ordered this visit due to bone exposure in wound. New orders for x-ray to left foot/ankle, CBC (complete blood count), CRP (C-Reactive Protein), and ESR (erythrocyte sedimentation rate). Wound status was documented as stable with a size of Pre-Debridement Measurement: 6 x 4.5 x 0.7 cm and Post-Debridement Measurement: 6 x 4.5 x 0.7cm, 25-49 % slough, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a heavy amount of seropurulent drainage. Wound care orders were as follows: cleanse with wound cleanser, apply SSD, Collagen Hydrogel, Collagen Particles, Calcium alginate to base of the wound, secure with Superabsorbent, ABD, and rolled gauze, to be changed daily, and PRN. R52's Physician orders, dated 6/4/25 at 2:01 PM, documented CBC WITH DIFF (differential), C-Reactive Protein (CRP), Sedimentation Rate Erythrocyte (ESR), one time only related to disruption of wound and to obtain x-ray of left ankle/foot 2 views one time a day every 1 day(s) related to non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin. R52's TAR documented on 6/5/25 the left ankle x-rays were completed. R52's TAR documented on 6/6/25 the CBC WITH DIFF (differential), C-Reactive Protein (CRP) and ESR were completed. R52's Lab Results for CBC WITH DIFF (differential), C-Reactive Protein (CRP), Sedimentation Rate Erythrocyte (ESR) documented a reported date of 6/7/25 at 4:14 AM, which included a high WBC (white blood cell count) of 18.05, a high CRP of 157.26 and a high ESR of 120. There was no documentation from 6/4 through 6/10 as the status of V18's, Wound Nurse Practitioner, request for lab work. R52's Hospital Discharge Summary, dated 6/18/25, documented he was admitted for sepsis and during his admission he was treated for osteomyelitis of his left foot involving IV antibiotics, surgical debridement, an MRI that showed severe progression of the previously seen osteomyelitis, and a PICC (peripherally inserted central catheter) line placed for long term IV antibiotics. Wound care orders were documented as	S9999		

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BRIA OF GODFREY	1623 29 WEST DELMAR , GODFREY, Illinois, 62035

(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 follows: left heel and lateral ankle: change every Mon/Wed/Fri (Monday/Wednesday/Friday), apply black foam to the wound beds, Adaptic to the left heel, cover with drape. Therapy settings as follows: -125 mm Hg (millimeter of mercury) continuous pressure with black foam. If unable to maintain a seal or wound vac (vacuum) therapy is off for more than 2 hours, remove entire vac dressing and lightly pack with gauze moistened with Vashe, cover with ABD and rolled gauze, change BID (twice a day). The Hospital Discharge Summary documented the following intravenous antibiotics to be started on 6/19/25 and be given daily, Vancomycin and Ceftriaxone. R52's Progress Note, dated 6/19/25, documented he returned from the hospital at 9:00 AM. R52's TAR and Physician's Orders, dated 6/19/25-6/22/25, documented no active wound care treatment orders. R52's TAR and Physician's Order did not document the discharge order for wound vac was initiated upon R52' readmission to the facility. R52's June 2025 MAR (Medication Administration Record) documented Ceftriaxone 2000 mg (milligram) to be given intravenously one time daily for 5 days was ordered on 6/19/25, but not administered on 6/19/25, due to administration time change. A new order for Ceftriaxone 2000 mg (milligram) intravenously at bedtime for osteomyelitis for 5 Days was started on 6/20/25. R52's June 2025 MAR continued to document Vancomycin 1250 mg to be given intravenously one time a day starting on 6/20/25. On 6/21/25, R52's MAR documented he did not receive his Vancomycin due to sleeping and there were no orders placed to start it on 6/19/25. R52's MAR documented he missed a total of two doses in the four days he was at the facility, on 6/19/25, the day he returned, and again on 6/21/25 when he was sleeping. R52's TAR and Physician's Orders, dated 6/23/25, documented orders for his left DFU as follows: apply moistened gauze of Vashe cover with ABD and rolled gauze change BID. R55's TAR documented no wound treatment was administered to his left DFU from 6/19/25-6/23/25. R52's Provider Progress Notes, dated 6/24/25, documented he was seen on 6/19/25 for readmission to facility; R52 was sent to the ER (emergency room) on 6/10 for generalized weakness and AMS (alerted mental status) and admitted with UTI (urinary tract infection)/sepsis, and osteomyelitis left calcaneus.	S9999		

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S9999	Continued from page 11 R52 underwent debridement of tissue and bone left calcaneus, was treated with IV antibiotics, and has a PICC line to LUE (left upper extremity) for continuation of IV antibiotic. R52's ED (emergency department) to Hospital-Admission paperwork, dated 6/23/25, documented final diagnosis included sepsis and was seen in the ICU after transferring from the ED where it was included, he had been discharged from the hospital 6/18/25 after being treated for left foot heel osteomyelitis and MRSA with a PICC line on Vancomycin and Ceftriaxone for long term antibiotic treatment. R52's Hospital Updates, date 7/23/25, documented active problems he was being treated for included, in part, acute osteomyelitis of left foot, catheter associated urinary tract infection and peripheral arterial disease. The Hospital Updates dated 7/23/25 also documented that R52's left DFU bone culture was positive for MRSA (Methicillin-resistant Staphylococcus aureus) and required treatment in the ICU during this time. R52's Hospital Discharge Summary, dated 7/24/25, documented he was admitted to the hospital from 6/23/25-7/24/25. The summary continued to document his wound care orders were as follows: for left medial heel, cleanse with Vashe, cut Aquacel AG to size of wound and place on the wound bed, and cover with 4x4s then heavy-duty ABDs daily. R52's Wound Consultant's Skin and Wound Note, dated 7/30/25, documented his left DFU wound status was improving without complications with a size of 4.5 cm x 3.5 cm x 0.7 cm, exposed tissues: epithelium, dermis, and subcutaneous; exudate was a moderate amount of serous drainage. The treatment orders were as follows: cleanse with 0.125% Dakins solution, apply Aquacel AG to base of the wound, secure with ABD, and rolled gauze to be changed daily, and PRN. R52's TAR and Physician's Orders, dated 7/24/25, documented orders for his left DFU as follows: apply moistened gauze of Vashe cover with ABD and rolled gauze to be changed BID every day and evening shift with a start date of 6/23/25 and end date of 8/4/25. On 8/4/25 at 3:05 PM, V10, Wound Nurse, was finishing up R52's wound care. R52 had a new dressing and what could be visualized was an absorbent pad wrapped in rolled gauze. V10 stated the dressing for R52's left heel wound contained Vashe moistened gauze, abdominal pad, and rolled gauze. V10 stated the dressing is twice	S9999		

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S9999	Continued from page 12 a day. After wound care was completed, V10 reviewed the wound report from last week and stated R52's wound orders were to use Dakins followed by Aquacel Ag with an abdominal pad and rolled gauze daily. V10 stated she must have forgot to update them. V10 stated the dressing she just applied were orders from prior to his hospitalization that never changed when he came back, so they just kept the old order. V10 stated she is supposed to review and update the wound report weekly. On 8/5/25 at 8:25 AM, R52 stated he's had the left foot wound for a couple years now and is not sure what it's from. R52 stated the specialist at the hospital told him he'll probably lose his foot. R52 stated his recent hospitalizations were longer due to all his infections. R52 stated he had a wound vacuum on his left foot at the hospital in June, but did not get one at the facility when he returned. R52 stated he's definitely worried about losing his foot. On 8/5/25 at 10:58 AM, V2, Director of Nursing, stated the facility changed wound care companies back in February or March, and since then V18 (wound Nurse Practitioner) has been seeing R52's wound care. V2 stated V18 comes every Wednesday and does her rounds with V10 (wound nurse) or another nurse if V10 isn't available, and they will assist V18 with her treatment. V2 stated during V18's rounds, she will take wound pictures and measurements, then have the new wound dressing applied with the nurse assisting her. V2 stated V18 completes a weekly wound report and sends it to her and the wound nurse for review. V2 stated the wound nurse (V10) is responsible for updating the orders from the wound report weekly. V2 stated she could not see wound care orders updated on R52's chart after returning from the hospital on 4/2/25, 6/19/25, or 7/24/25. V2 stated R52 was never started on a wound vacuum because the hospital never communicated with the facility that he would be needing one, and they needed time to order it. V2 stated she would expect the nurse to make a progress note in R52's chart documenting the concern with the wound vacuum not being available and to contact the provider to update those wound care orders appropriately. V2 stated the facility doesn't keep Vancomycin in stock, so it usually takes about a day to get, and that was probably why R52 didn't get his dose on 6/19/25, but there is no documentation that is why. V2 stated sleeping would not be a reason to miss a dose of Vancomycin as documented on 6/21/25. V2 stated V10 is supposed to assess all admissions with wounds and update their orders with photos and measurements with in at least 24 hours. V10 was not here on 6/19/25, but was here on 6/20/25, and should have updated his wound orders then. Over the weekends,	S9999		

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S9999	Continued from page 13 floor nurses can always contact the on-call provider about wound care orders when V10 is not here. V2 stated she does not know why R52's wound care orders were not put in from 6/19/25-6/23/25 and does not see any documentation of him getting wound care those days. V2 state V10 is not looking at the weekly orders or hospital orders; she's not doing her job. V2 stated R52's Osteomyelitis/wound is not going to get better without the proper care and following physician's orders. V2 stated, "There is a lack of communication between the providers and us." V2 stated R52's wound care could have been better. On 8/12/25 at 11:32 AM, V22, Medical Director, stated he would expect wound care orders to be followed as recommended by the provider and it is a concern there were no wound care orders in place from 4/2/25-4/21/25, and again on 6/19/25-6/23/25. V22 stated he would expect the nurses to notify a provider if a resident returned from the hospital requiring a wound vac that was not available. V22 stated he would expect abnormal lab values to be reported to a provider within 24 hours. On 8/5/25 at 11:58 AM, V18, Wound Nurse Practitioner, stated she was never notified R52 had ever came back with a wound vacuum order for his left foot. V18 stated she sent R52 out to the hospital because of concerns for osteomyelitis around the beginning of June. V18 stated she was never notified of R52's lab results, and they didn't notify the primary care provider of them either. V18 stated she had to give the facility orders to send R52 to the hospital because she found out his labs were positive for osteomyelitis and concerns for sepsis; the facility did not make that decision. V18 stated she never approved R52's wound care orders to be changed to the secondary wound vacuum treatment as his primary. V18 stated the facility doesn't always communicate with her when residents return from the hospital. V18 stated R52 missing doses of Vancomycin is a delay in care and puts him at increased risk for infection and rehospitalization. V18 stated the facility never communicated with her about R52 being treated for osteomyelitis while he was hospitalized. V18 stated the facility shouldn't have accepted R52 on a wound vacuum if they didn't have one available when he arrived. V18 stated she was not aware R52 didn't have wound care orders in place or documentation of any being done while he returned from 6/19/25-6/23/25. V18 stated, "There's a systems error not following orders and updating them which delays wound care and could have contributed to his rehospitalization and delayed healing." V18 stated she has been aggravated as a provider that she was not notified about R52's lab	S9999		

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S9999	Continued from page 14 results back in June prior to her having him sent out. V18 stated she had concerns of R52 getting osteomyelitis and ordered labs to be done to confirm, but the facility never notified her or the primary provider about his results. V18 stated she didn't get R52's lab results for almost a week later and that was a big error on their part. V18 stated she is aggravated that she had to reach out to the facility about the lab results, which ended up being positive for osteomyelitis. V18 stated when she does the rounds at the facility a nurse will be with her, and she will have them do the new dressing so they know and will answer all questions they have at that time, and she is always available by phone. V18 stated she will make up a report for the day on her rounds and sends it to the DON and Wound Nurse, or whoever else they request to have it. V18 stated last week she doesn't understand why they would pull the actual wound nurse from doing rounds with her, to pick up documents because the internet was having issues and put the MDS (Minimum Data Set) in her place. V18 stated she was aggravated they pulled the one nurse whose job it was for wounds to leave while she was there doing rounds. V18 stated the report orders she completes after her rounds should be put in by the end of the day. V18 stated she considers wound care not being done as ordered the same as a medication error and was not aware the facility was not following her orders. V18 stated the facility not implementing proper wound care delayed his wound healing, which increased his risk of infection, and could have the potential of R52 losing his foot in the future if continued. V18 stated the errors the facility has made with R52 could delay his healing and tomorrow he will be the first one she sees. V18 stated since she sent him to the hospital in June, she's had concerns about him and when she's called the facility for updates on him, they didn't have any on his wound infection for her. V18 stated R52's wound started out as a diabetic foot ulcer. V18 stated diabetics have a higher risk of infection and prolonged wound healing. On 8/7/25 at 10:37 AM, V2 stated there is no way to prove wound care was completed for R52 on 4/2/25-4/21/25 and again on 6/19/25-6/23/25 with no documentation. 2. R22's Face Sheet documented he was admitted to the facility on 10/4/24, with diagnoses of chronic respiratory failure, type two diabetes mellitus, and cellulitis. R22's MDS, dated 7/11/25, documented he was cognitively intact.	S9999		

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S9999	Continued from page 15 R22's Care Plan, dated 10/16/24, documented he was at risk for skin complications. R22's Acute Care Progress Note, dated 7/21/25, documented V17, Nurse Practitioner, NP, stated, "(R22) presents today with ulcers of his bilateral lower extremities that are not healing. He has noted increased pain swelling and warmth associated with it. He's currently on gabapentin hundred milligrams that was increased approximately 1 month ago and continues to complain of pain. He was recently in the hospital for leg swelling and difficulties breathing. Currently denies any chest pain, shortness of breath, headaches, dizziness or any stomach complaints. He has never seen a wound specialist." V17 ordered Doxycycline 100mg PO (by mouth) BID (twice daily) x (for) 10 days for cellulitis, BLE (bilateral lower extremities), Mupirocin External Ointment 2 % apply to BLE nightly. R22's Acute Care Progress Note, dated 7/24/25, documented V17 (NP) stated, "(R22) follows up today from Monday regarding infection of his bilateral lower extremities and nonhealing wounds. Unfortunately, he was unable to start the topical antibiotics, or the oral antibiotics continues to have swelling redness and pain especially in the left lower extremity." V17 again ordered Doxycycline 100mg PO (by mouth) BID (twice daily) x (for) 10 days for cellulitis, BLE (bilateral lower extremities), Mupirocin External Ointment 2 % apply to BLE nightly. R22's Physician Orders and MAR (Medication Administration Record), dated 7/21/25-8/1/25, document no active orders for Doxycycline and from 7/21/25-7/24/25 no orders for Mupirocin ointment. On 7/28/25 at 10:10 AM, R22 stated he's been waiting on the facility to get him his antibiotic for his leg wounds almost a week. R22 stated they haven't done anything for his wounds; they finally started dressing in last night with ointment. R22's left lower leg had three nickel sized open wounds with dry flaky, red skin surrounding. R22 stated this place is bad, he wouldn't send his worst enemy here. On 7/29/25 at 2:08 PM, R22 stated his left lower leg is still throbbing and usually an 8-9 out of 10 on the pain scale while he is up and when he is sitting it can get down to a 4, but will have moments where it's a shooting pain. R22 stated, "It pisses me off they haven't been able to start me on my antibiotic." R22 stated without the oral antibiotic, he is concerned his infection won't heal and this is delaying improvement.	S9999		

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S9999	Continued from page 16 On 7/29/25 at 1:51 PM, V10, Infection Preventionist/Wound Nurse, stated R22's cellulitis is currently being treated with Mupirocin on both legs and that's all that is ordered. V10 pulled up V17's visit notes and read R22 was to start ciprofloxacin for cellulitis and Mupirocin on legs. V10 stated she was not aware R22 was supposed to be on ciprofloxacin, and the nurse is supposed to communicate with her on these details and there was a communication problem somewhere. V10 stated her expectations for anyone prescribed antibiotics is that they are started within 24 hours even if it is not available, there are ways to get it through pharmacy or stock. On 8/4/25 at 3:46 PM, V17, Nurse Practitioner, stated she was worried about R22's leg wounds and concerned about cellulitis. V17 stated she messaged her nurse to put the orders in and doesn't know why they weren't. V17 stated she expects her orders are received and put in as recommended. V17 stated it is significant for antibiotics not to be started for an infection. V17 stated she has concerns with the communication or lack of communication with the facility. 3.R19's treatment order, dated 8/13/2025 with start date 8/12/2025, documents to cleanse right great with wound cleanser, pat dry, and apply skin prep to scabbed area and leave open to air daily until resolved. every day shift. On 8/13/2025 at 9:14AM, V2, Director of Nursing (DON), provided wound treatment to R19's right great toe. Prior to entering room to do treatment, V2 stated, " I am going to use normal saline I am out of wound cleanser." V2 then looked in treatment cart and obtained wound cleanser. V2 then removed sock from R19's right foot. R19's small, scabbed wound to right great toe had no drainage or signs of infection. V2, with wound cleanser on 4x4, cleansed R19's right great toe, then removed alcohol pad and rubbed on wound. V2 then stated, "I should have used skin prep", then went to cart and obtained skin prep and applied to scabbed area on R19's right great toe. On 8/13/2025 at 10:10 AM, V1, Administrator, stated she would expect wound treatments to be done as ordered by the physician. The facility's Skin Management Treatment/General Wound Treatment Policy, last reviewed on 4/2024, documented an order is required for all treatment orders. The policy continued to document treatment guidelines involved reviewing the physicians order in the EHR	S9999		

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S9999	Continued from page 17 (electronic health record) and to document routine or PRN treatments in the TAR of the EHR. The facility's Medication Administration Policy, reviewed last on 4/2024, documented if the physician's order cannot be followed for any reason, the physician should be notified in a timely manner, and a note should reflect the situation in the resident's medical record. The facility's Physician's Orders Policy, last revised on 9/2024, documented physician orders are followed as written; if there is a question about the order, contact the physician for clarification and follow through with orders by making appropriate contact or notification. (A) 2 of 2 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1210. General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 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	S9999		

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S9999	Continued from page 18 receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement fall interventions for 1 of 3 residents (R7) reviewed for accidents in the sample of 28. This failure resulted in R7 falling off side of bed and requiring hospitalization for a subarachnoid hemorrhage and large left frontotemporal scalp hematoma. Findings include: R7's face sheet, dated 7/31/2025, documents in part diagnosis of Parkinson's disease, Traumatic subarachnoid hemorrhage without loss of consciousness. R7's fall risk assessment, dated 11/27/2023, documents a score of 23 high risk for falls, with 10 or greater being high risk for fall. R7's fall risk assessment, date 11/22/2024, documents a score of 25, with 10 or greater being high rids for fall. R7's fall risk assessment documents history of fall. R7's Minimum Data Set (MDS), dated 5/23/2025, documents R7 is severely cognitively impaired. R7's MDs documents R7 requires 02- substantial/maximal assistance; helper does more than half the effort, Helper lifts or holds trunk or limbs and provides more than half the effort for toileting/hygiene, shower, upper body dressing, lower body dressing and personal hygiene. R7s care plan, dated 11/27/2023, documents R7 is at risk for falls, cognitive deficits, functional deficits, poor balance and psychotropic meds. R7's care plan documents the following interventions; 1/29/24-remove resident from her room when she is restless and put her near the nurses station, 12/29/23-Bed placed in lowest position and a floor matt placed on the side of the bed. 2/21/25 Staff educated to place WC closer to bed and to lay resident back down prior to transfer if WC is not close enough d/t resident's poor trunk control. R7's fall report investigation, dated 2/21/2025, documents Certified Nursing Assistant (CNA) requested	S9999		

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S9999	Continued from page 19 nurse presence in resident's room. The report documents CNA stated had resident sitting on the side of the bed and getting dressed. The report documents CNA stated turned around and resident was on the floor. R7's fall report documents upon arrival to room R7 found sitting on the floor on the left side of her bed, huge amount of blood noted on the floor and profuse amount of blood noted around resident's face and in her hair. Report documents large hematoma noted to the left of forehead. Report documents pressure applied and 911 called. The hospital healthcare notes, dated 2/21/2025, documents reason for visit fall with diagnosis of subarachnoid hemorrhage. The facility progress note readmit visit, dated 2/25/2025, documents R7 being seen following recent admission after a fall on 2/21/2025. Note documents was sent tot hospital from the facility where diagnosed with subarachnoid hemorrhage. On 8/5/2025 at 12:46PM, V2, Director of Nursing/DON, stated R7's wheelchair was in the room, and staff and turned to get the chair. V2 stated staff were educated on placing the wheelchair closer to bed for transfer, and if wheelchair not close, lay resident down prior to getting wheelchair. V2 stated R7 does have trunk instability related to Parkinsons. On 8/12/2025 at 11;44AM V22, Medical Director and Primary Care Physician stated the facility is expected to provide precautions for falls as in care plan (A)	S9999		