STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145862	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLTOP SKILLED NSG & REHAB	**910 WEST POLK STREET CHARLESTON, IL 61920**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review the facility failed to implement its Abuse Prevention Policy for four residents (R1, R2, R4, R5) of four residents reviewed for Abuse in a sample list of 15 residents. Findings include: The facility's undated policy Abuse Prevention Policy states The purpose of this policy and the Abuse Prevention Program is to describe the process of identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This policy also states, implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. This policy also states Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. This policy also documents, Sexual Abuse - nonconsensual sexual contact of any type with a resident. This policy also states Documentation in the resident's chart should reflect the resident's physical and emotional status as well as any medical and nursing interventions implemented. 1. R1's Grievance/Complaint resolution Report dated 4/12/20 documents (R1) reported to nurse (R1) wanted out of room because roommate was a (derogatory term for homosexual male) and (R2) asked (R1) to sexually gratify (R2). On 7/20/20 at 11:00am V1 denied an investigation was done concerning this because I talked to (R1) and (R1) denied any contact. I did not consider it abuse. V1 identified the nurse referred to on the grievance as V4 (Licensed Practical Nurse/LPN). No documentation of this occurrence is observed on R1's or R2's medical record. 2. R4's Summary of Investigative Findings dated 5/8/20 states At approximately 1:15 PM V1 (Administrator) was notified by the nurse (V3, Licensed Practical Nurse/LPN) of an allegation of resident to resident abuse between R4 and R5. On 7/20/20 at 11:00 AM V1 stated R4 reported to (V3) on 5/3/20 R4 had some vaginal bleeding after R5 put four fingers in R4's vagina. R4 stated that she didn't want R5 to touch her but R5 did. I believe R4 because R5 had dried blood on R5's knuckles and cuticles. The police were called and at first R5 stated it was consensual but then admitted R5 had touched R4's vagina with R5's fingers. R5 was arrested and is still in the county jail. R4 went home with a care giver after being at the hospital for a rape kit to be done. R5 stated the contact had occurred sometime after dinner 5/2/20. V1 denied there was ever any other sexually inappropriate behavior observed from R5 prior to this incident. V1 stated R5 was helpful to other residents and even pushed other residents in wheelchairs sometimes. We had no reason to believe R5 would have done this. R4 and R4's family are the nicest people. R4's husband was even here for a while. R4 was content and visited with staff and other residents. There had not been anything between R4 and R5 until this. Documentation in R4's chart did not reflect the resident's physical and emotional status or even that R4 was sent to the hospital until after the fact.
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** Based on interview and record review the facility failed to report reasonable suspicion of a crime for two residents (R1, R2) of four residents reviewed for sexual abuse in a sample list of 15 residents. Findings include: On 7/27/20 at 1:11PM V4 (Licensed Practical Nurse/LPN) stated On 4/12/20 R1 said 'You gotta get me out of this room. R2's a q***(derogatory). R2 tried to j*** (sexual reference) me off and I had to push him off me.' It was a Sunday; I know I talked on the phone with V1 (Administrator) about this. On 7/27/20 at 2:10PM V43 (Certified Nurse's Aide/CNA) stated R2 plays with himself all the time. They have moved a couple roommates out because of that. I can't remember who. On (4/12/20) R1 put his light on. I went into the room and R1 said 'Get me the f*** (expletive) out of this room.' I asked why and R1 told me R2 had asked R1 to suck his d*** (penis). R1 said that R2 had touched his penis. V43 verbalized that she was sure she had called V1 and told V1 about this incident. R1's Grievance/Complaint resolution Report dated 4/12/20 documents R1 reported to nurse R1 wanted out of room because roommate was a (derogatory term for homosexual male) and R2 asked R1 to sexually gratify R2. The facility's undated policy Abuse Prevention Policy states The purpose of this policy and the Abuse Prevention Program is to describe the process of identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This policy also states, implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. This policy also states Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. This policy also documents, Sexual Abuse - nonconsensual sexual contact of any type with a resident. On 7/20/20 at 11:00 AM V1 (Administrator) denied an investigation was done concerning this because I talked to R1 and R1 denied any contact. I did not consider it abuse. V1 identified the nurse referred to on the grievance as (V4 Licensed Practical Nurse/LPN). No documentation of this occurrence is observed on R1's or R2's medical record. When asked why R1's request for a roommate change was not addressed V1 stated R1 denied it and I didn't hear anything more about it. R1 was in the room with R2 until 7/11/20 when he was moved to an isolation room because of a respiratory infection. On 7/20/20 at 11:00 AM V1 denied reporting to local law authorities since this was not considered by V1 to be abuse.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review the facility failed to report an allegation of abuse for two residents (R1, R2) to state agency of four residents reviewed for sexual abuse in a sample list of 15 residents. Finding include: On 7/27/20 at 1:11PM V4 (Licensed Practical Nurse/LPN) stated, On 4/12/20 R1 said 'You gotta get me out of this room. R2's a q*** (derogatory). R2 tried to j*** (sexual reference) me off and I had to push him off me.' It was a Sunday. I know I talked on the phone with V1(Administrator) about this. On 7/27/20 at 2:10PM V43 (Certified Nurse's Aide/CNA) stated R2 plays with himself all the time. They have moved a couple roommates out because of that. I can't remember who. On (4/12/20) R1 put his light on. I went into the room and R1 said 'Get me the f*** (expletive) out of this room.' I asked why and R1 told me R2 had asked R1 to suck his d*** (penis). R1 said that R2 had touched his penis. V43 verbalized that she was sure she had called V1 and told V1 about this incident. R1's Grievance/Complaint resolution Report dated 4/12/20 documents R1 reported to nurse R1 wanted out of room because roommate was a (derogatory term for homosexual male) and R2 asked R1 to sexually gratify R2. On 7/20/20 at 11:00 AM V1 denied an investigation was done concerning this because I talked to R1 and R1 denied

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) any contact. I did not consider it abuse. V1 identified the nurse referred to on the grievance as V4 (Licensed Practical Nurse/LPN). No documentation of this occurrence is observed on R1's or R2's medical record. When asked why R1's request for a roommate change was not addressed V1 stated R1 denied it and I didn't hear anything more about it. R1 was in the room with R2 until 7/11/20 when he was moved to an isolation room because of a respiratory infection. On 7/20/20 at 11:00 AM V1 denied reporting to State Agency since she did not consider this to be abuse.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on interview and record review the facility failed to prevent/correct sexual abuse for two residents (R1, R2) of four residents reviewed for resident to resident sexual abuse in a sample list of 15 residents. Findings include: On 7/27/20 at 1:11PM V4 (Licensed Practical Nurse/LPN) stated On 4/12/20 R1 said You gotta get me out of this room. R2's a q*** (derogatory). R2 tried to j*** (sexual reference) me off and I had to push him off me.' It was a Sunday. I know I talked on the phone with V1 (Administrator) about this. On 7/27/20 at 2:10PM V43 (Certified Nurse's Aide/CNA) stated R2 plays with himself all the time. They have moved a couple roommates out because of that. I can't remember who. On (4/12/20) R1 put his light on. I went into the room and R1 said 'Get me the f*** (expletive) out of this room.' I asked why and R1 told me R2 had asked R1 to suck his d*** (penis). R1 said that R2 had touched his penis. V43 verbalized that she was sure she had called V1 and told V1 about this incident. R1's Grievance/Complaint resolution Report dated 4/12/20 documents R1 reported to nurse R1 wanted out of room because roommate was a (derogatory term for homosexual male) and R2 asked R1 to sexually gratify R2. On 7/20/20 at 11:00 AM V1 denied an investigation was done concerning this because I talked to R1 and R1 denied any contact. I did not consider it abuse. V1 identified the nurse referred to on the grievance as V4 (Licensed Practical Nurse/LPN). No documentation of this occurrence is observed on R1's or R2's medical record. When asked why R1's request for a roommate change was not addressed, V1 stated R1 denied it and I didn't hear anything more about it. R1 was in the room with R2 until 7/11/20 when he was moved to an isolation room because of a respiratory infection. On 7/20/20 at 11:00 AM V1 verbalized that R1 was not moved from the room with R2 since this was not considered by V1 to be abuse.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide dining assistance for one of three residents (R6) reviewed for dining assistance in the sample list of 15. Findings include: R6's undated Census sheet documents R6 admitted to the facility on [DATE] and discharged on [DATE]. R6's Long Term/Intermediate Care Nursing Summary dated 5/6/20 documents R6 has [DIAGNOSES REDACTED]. R6's Admission Minimum (MDS) data set [DATE] documents R6 was independent with setup for eating. R6's Care Plan revised on 5/8/20 documents R6 needs extensive assistance with ADLs (Activities of Daily Living) related to impaired decision-making and weakness. This Care Plan documents an intervention dated 5/6/20 that R6 is independent with eating. R6's weight log documents R6's weights on 5/9/20 as 157 lbs. (pounds), 5/13/20 as 156 lbs., and 5/23/20 as 150.5 lbs. (5.5 lbs. loss in ten days.) On 7/21/20 at 10:38 AM R6 stated when R6 resided in the facility, R6 was unable to feed R6's self due to R6's hands shaking and causing R6 to spill food. R6 stated the staff did not offer to assist R6 with eating, even though there were orders from the hospital saying R6 needed assistance with eating. R6 stated R6 mentioned to unidentified staff that R6 needed assistance, and R6 was told that since R6 can move R6's arms R6 should be able to feed R6's self. On 7/20/20 at 1:40 PM V5 (Certified Nursing Assistant/CNA) stated V5 provided care for R6 during May/June. V5 stated R6 needed extensive assistance of two staff for most ADLs. V5 stated staff did not assist R6 with eating since R6 could feed R6's self, but R6 would frequently spill food all over. On 7/21/20 at 3:10 PM V2 (Director of Nursing) confirmed that R6's hospital nursing summary documented that R6 needed assistance with eating and that R6 had a 5 lbs. weight loss between 5/13/20 and 5/23/20. V2 stated staff should have been assisting R6 with eating. The facility's Feeding the Dependent Resident policy dated 9/15/19 documents It is the responsibility of the Nursing Staff to ensure that all residents who require assistance with feeding receive the needed assistance. It is the responsibility of the Care Plan Coordinator to properly assess all residents and identify those that require assistance with feeding on their care plan.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide timely treatment for [REDACTED]. Findings include: R6's Admission Minimum (MDS) data set [DATE] documents R6 uses extensive assistance of two staff for toileting and has a urinary catheter. R6's Care Plan dated 5/7/20 documents R6 as high risk for urinary tract infections due to the use of an indwelling urinary catheter. This Care Plan documents interventions to obtain labs as ordered and monitor and notify the physician for fever, abdominal tenderness, flank pain, altered mental status, malodor, hematuria or abnormal urine clarity/consistency. R6's Progress Note dated 5/18/20 at 10:23 AM by V15 (Licensed Practical Nurse/LPN) documents R6 was experiencing fever, new or worsened hallucinations and delusions as well as foul smelling cloudy urine. This note documents V15 notified V17 (Physician) and received orders to obtain a urine sample for UA (Urinalysis) and C&S (Culture and Sensitivity.) R6's Urine Culture and Sensitivity dated 5/24/20 documents R6's urine was collected on 5/22/20 and had greater than 100,000 colony forming units/milliliter of Proteus Mirabilis (bacteria) indicating R6 had a UTI (Urinary Tract Infection.) This report documents a hand-written note for Keflex (antibiotic) 250 mg (milligram) three times daily for one week. There is no documentation in R6's medical record that a urine sample was obtained prior to 5/22/20. R6's Physician order [REDACTED]. R6's May 2020 Medication Administration Record [REDACTED]. R6's Hospital Emergency Department Note by V19 (Physician) dated 6/3/20 at 4:21 PM documents R6 presented with fever and was discharged from the nursing home 2 days ago. V19 documents R6's [DIAGNOSES REDACTED]. On 7/22/20 at 1:00 PM V15 (LPN) stated on 5/18/20 R6 became lethargic and V15 notified V17 (Physician) and received orders for a UA C&S. V15 stated V15 did not obtain the urine sample that day and that the evening or night shift should have obtained the urine sample. On 7/22/20 at 12:56 PM V2 (Director of Nursing) confirmed R6 had an order to obtain a UA with C&S on 5/18, and stated R6's urine sample was not sent to the lab until 5/22 (4 days later). V2 stated V2 did not know why it took that long to obtain the urine since R6 had a catheter at that time. V2 stated the urine should have been obtained sooner than 5/22/20. V2 confirmed R6 did not receive antibiotics for R6's UTI until 5/24/20, six days after R6's initial symptoms of UTI. On 7/22/20 at 1:14 PM V17 stated V17 would expect the nurses to have obtained R6's urine sample within 24 hours of giving the order.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify pressure ulcers, assess and measure wounds upon admission, implement pressure relieving interventions, and obtain treatment orders and implement individual treatment orders for wounds for two of three residents (R6, R8) reviewed for pressure ulcers in the sample list of 15. Findings include: 1. R6's Census dated 7/22/20 documents R6 admitted to the facility on [DATE]. R6's Admission Nursing assessment dated [DATE] at 11:21 PM documents R6 admitted [MEDICAL CONDITION], [DIAGNOSES REDACTED], and [DIAGNOSES REDACTED]. This assessment documents R6's skin was intact upon admission. R6's Shower Sheet dated 5/8/20 documents R6 had redness to R6's buttocks. R6's Shower Sheet dated 5/9/20 signed by V15 (Licensed Practical Nurse/LPN) documents R6 had redness to R6's buttocks and R6 reported having the reddened areas upon admission. V15 documented the reddened areas as superficial with measurements of 6.5 centimeters (cm) by 3 cm and 4.5 cm by 1 cm. R6's Initial Wound Evaluation and Management Summary by V16 (Wound Physician) dated 5/12/20 documents R6's shear wound to the sacrum measured 10 cm long by 8 cm wide with no measurable depth. V16 documented a treatment plan to apply house barrier cream to R6's sacral wound three times daily. R6's Wound Evaluation and Management Summary by V16 dated 5/26/20 documents R6's shear wound to the sacrum measured 6 cm long by 5 cm wide by 0.1 cm deep. V16 documented the wound had 10 percent slough (necrotic tissue) and required debridement. This summary also documents R6 had a shear wound to the left buttock that measured 2.2 cm long by 2 cm wide by 0.1 cm deep. R6's Admission Minimum Data Set ((MDS) dated [DATE] documents R6 used extensive assistance of two staff for bed mobility and transfers. This MDS documents R6 was at risk of developing pressure ulcers, had no pressure ulcers upon admission, and R6 used a pressure relieving device in bed. R6's CAA (Care Area Assessment) dated 5/19/20

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) documents R6 is at risk for developing pressure ulcers with risk factors including pressure, incontinence, immobility, and poor nutrition. This CAA documents R6 needs a special mattress or seat cushion to reduce or relieve pressure. R6's Care Plan revised on 5/26/20 documents R6 has impaired skin integrity of the sacrum and left buttocks related to shearing. This care plan does not document any interventions for the use of pressure relieving devices. R6's Recapitulation of Stay dated 6/2/20 and signed by V21 (LPN) documents R6's discharge summary including cleanse wound daily and apply calcium alginate and then cover change daily. R6's May 2020 Treatment Administration Record (TAR) documents a treatment order beginning on 5/13/20 to apply house barrier cream to the sacral region three times daily. There are no documented treatments to R6's sacral wound prior to 5/13/20. There is no documentation in R6's medical record that V16 (Wound Physician) was notified of R6's buttock wounds until 5/12/20 (three days after being identified,) and no documentation of treatment orders for R6's buttock wound prior to 5/13/20. There is no documentation in R6's Medical Record for a treatment order to apply calcium alginate to R6's wounds. On 7/21/20 at 1:51PM V21 (LPN) stated V21 gave R6 verbal discharge instructions on 6/2/20 on wound care, medications, home health services, and follow up physician appointments. V21 stated V21 gave R6 a copy of R6's physician orders, recapitulation of stay and wound care supplies. V21 stated V21 would have copied the calcium alginate treatment order from R6's physician orders. On 7/21/20 at 2:49 PM V15 (LPN) stated V15 was the nurse who signed R6's shower sheet on 5/9/20. V15 stated R6 had admitted to the facility with the wound to his sacrum and the wound was due to shearing caused by R6 scooting down in R6's recliner. V15 stated R6 refused to lie down in bed and spent most of his time sleeping in R6's recliner. V15 stated V15 notified V16 of the sacral wound on 5/9/20 and received orders to apply barrier cream. V15 confirmed V15 did not document in R6's medical record that V16 was notified of the wound or document the barrier cream orders. On 7/21/20 at 3:10 PM V2 (Director of Nursing) stated that R6 admitted to the facility with the sacral wound, and the left buttock wound was facility acquired. V2 stated R6's wounds were considered to be shearing, but pressure contributed to the development of the wounds. V2 stated R6 had lost a lot of functional mobility related to R6's diagnosis, was using a slide board for transfers, and would often scoot R6's self to the edge of the bed. V2 stated the facility did not implement a pressure relieving device in R6's wheelchair or recliner. V2 stated R6 was not cooperative with care and confirmed that R6's medical record does not document R6's refusal of care. V2 stated R6 had orders for house barrier cream to the sacral and buttock wound and did not have orders for calcium alginate. On 7/22/20 at 10:05 AM V12 (MDS Coordinator) stated R6 was admitted with the sacral shear wounds from the hospital. V12 stated R6's Admission MDS does not document R6 as having pressure ulcers since V12 did not think shear wounds were considered to be pressure ulcers. On 7/22/20 at 11:07 AM V2 confirmed that R6's medical record does not contain measurements of R6's sacral wound upon admission and there are no documented measurements of R6's wound until 5/9/20. V2 stated that there is no documentation that V16 was notified and treatment orders were obtained for R6's sacral wound until 5/12/20 (six days after admission). V2 stated the nurses are to obtain measurements of wounds upon admission and any time a wound is identified, and the physician should be notified to receive treatment orders. 2. R8's undated [DIAGNOSES REDACTED]. R8's Admission Nursing Assessment documents R8 admitted to the facility on [DATE] with wounds to the sacrum 6.5 cm long by 3 cm wide, right gluteal fold 1.5 cm by 1 cm and 0.7 cm by 1 cm, and bunions to the first and fifth toes. This assessment documents that R8 had pain to the sacrum and left foot wounds. R8's Wound assessment dated [DATE] documents R8's coccyx wound as a Stage 3 pressure ulcer that measured 6.5 cm by 3 cm and was covered by 50 percent slough (necrotic tissue). R8's Admission MDS dated [DATE] documents R8 used extensive assistance with bed mobility occurring only once or twice, and transfers did not occur during the 7 day look back period. This MDS documents R8 admitted to the facility with three Stage Three pressure ulcers. R8's Progress Notes are as follows: 1/21/20 at 3:36 PM recorded by V12 (LPN/MDS Coordinator) documents V12 received an admission report from the hospital that R8 had wounds to the left foot multiple toes, an unstageable wound to the coccyx, left gluteus abrasion, and moisture associated skin damage to R8's buttocks. 1/22/20 recorded by V17 (Physician) documents R8 was recently treated in the hospital for altered mental status, has a history of [MEDICAL CONDITION] with right below knee amputation, sacral decubitus ulcer, and left leg has gangrene (death of tissue) with an open wound. V17 documents R8's left leg wound has an odor and to continue current wound care. 1/31/20 at 7:20 PM by V12 documents (R8's) areas to the left foot that (R8) was admitted with have now opened and foul odor noted. Hospice notified, (V18 R8's Family) notified, (V17 Physician) notified. New order received - cleanse with NS (Normal Saline), (skin protectant) to peri wound, pack wound with Dakins soaked gauze and wrap with abd (Abdominal pad) and secure, change BID (Twice Daily) and PRN (As Needed). R8's January 2020 TAR documents a treatment that started on 1/24/20 to cleanse R8's buttock wounds, apply no sting skin protectant to the area surrounding the wound, and apply calcium alginate with a bordered dressing daily. This TAR documents a treatment that started on 1/24/20 to cleanse R8's coccyx wound and pack with Dakin's soaked gauze covered by a dry dressing daily. This TAR documents a treatment that started on 1/31/20 to cleanse R8's left foot Venous Stasis Ulcer, apply no sting skin protectant to the area surrounding the wound, apply Dakin's soaked gauze and wrap with an abdominal pad and gauze twice daily. There are no documented treatments administered to R8's buttock or coccyx wounds prior to 1/24/20 (three days after wounds were identified) and for R8's left foot wound prior to 1/31/20. R8's Initial Wound Evaluation And Management Summary dated 2/4/20 by V16 (Wound Physician) documents R8's left first toe wound had gangrene and measured 10 cm long by 3 cm wide by 0.5 cm deep and R8's left foot wound was unstageable due to necrosis and measured 10 cm long by 2 cm wide and immeasurable depth. This summary documents R8's sacral wound as Stage 3, measured 6 cm by 1 cm by 0.1 cm deep, was covered in 5 percent slough and required debridement. There are no documented measurements in R8's medical record of R8's left lateral foot wound or left first toe wound prior to 2/4/20 (14 days after identified upon admission). R8's Wound Evaluation and Management Summary dated 7/14/20 by V16 (Wound Physician) documents R8 has a Stage 3 left foot wound of greater than 150 days duration that measured 1.5 cm long by 1 cm wide by 0.2 cm deep with 25 percent necrotic tissue present. This summary documents R8 has an arterial wound to the left first toe that measured 1.5 cm by 0.7 cm by 0.5 cm that is 100 percent necrotic tissue. On 7/20/20 at 11:50 AM R8 was sitting in a geriatric wheelchair asleep. R8 had a pressure relieving boot on the left foot with a dressing dated 7/20/20 wrapped around R8's left foot. On 7/22/20 at 10:30 AM V16 stated R8 admitted to the facility with several wounds including the wound to the left foot. V16 stated R8 admitted to the facility on hospice and V16 did not get the approval to see R8 until two weeks after R8 admitted to the facility. V16 stated if the staff observe wounds between V16's weekly rounding then they are to call V16 to obtain treatment orders. On 7/22/20 at 11:07 AM V2 stated R8 admitted to the facility with the sacral, right gluteal fold, and left foot/toe wounds on 1/21/20. V2 confirmed that R8's medical record does not contain measurements of R8's left foot wound until 2/4/20. V2 confirmed there were no documented treatments administered to R8's wounds to the sacrum and buttocks prior to 1/24/20 (3 days after the wounds were identified.) and the left foot wound prior to 1/31/20. V2 stated the nurses are to obtain measurements of wounds upon admission and any time a wound is identified, and the physician should be notified to receive treatment orders. The facility's Pressure Ulcer Prevention, Identification, and Treatment Policy dated 9/15/19 documents a stage 2 pressure ulcer as partial thickness of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, a stage 3 pressure ulcer as full thickness tissue loss and may include slough, undermining and tunneling, and an unstageable pressure ulcer as full thickness tissue loss in which the base of ulcer is covered by slough and/or eschar in the wound bed. This policy documents it is the responsibility of the Charge Nurse/Designee to care for pressure areas, ensure treatments are in place, provide treatments as ordered, and measure and document on the pressure areas weekly. This policy documents when a pressure ulcer is identified, whether in-house, or upon a resident's admission, the area will be assessed using Pressure Ulcer Risk Assessment and initial treatment started per physician's orders [REDACTED]. This policy documents that pressure ulcers will be documented upon identification and weekly until healed including characteristics of the wound, treatment and response, and prevention techniques.