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S 000	Initial Comments Initial complaint investigation #1814939 / IL 104552	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.1210a) 300.1210d)5) 300.1220b)2)3) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.	S9999		

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S9999	Continued From page 2 3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on observation, interview and record review the facility failed to identify areas of heel pressure prior to opening of wounds, to assess areas of injury when identified, and failed to implement a care plan and pressure relief interventions. The facility failed to ensure transportation was available to transport the resident to the wound doctor for an initial consultation as scheduled. These failures resulted in R2 developing 2 unstageable heel pressure ulcers, which required hospitalization for wound treatment on August 2, 2018.	S9999		

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This applies to 1 of 3 residents (R2) reviewed for pressure and medical appointments in a sample of 3.

The findings include:

On August 2, 2018 at 10:15 AM, R2 stated he missed his appointment last week. R2 stated the doctor was going to look at his wounds. R2 was lying on a standard mattress and had blue heel protectors on both feet. Elastic wrap bandages were in place over both heels. Both heels were resting on the mattress, and no offloading support was in place to relieve heel pressure.

The medical record for R2 shows he was admitted to the facility on June 28, 2018 with a diagnoses to including diabetes mellitus type II, history of CVA with right sided weakness and aphasia. R2 had been treated at the hospital from June 24 - 28, 2018 for worsening speech, and shortness of breath. R2 also has left atrial myxoma, chronic kidney disease stage 3, congestive heart failure with systolic ejection fraction of 20%, coronary heart disease, hypertension, intracranial bleed, osteoarthrosis, peripheral neuropathy and peripheral vascular disease. The initial comprehensive assessment on July 5, 2018 shows R2 is at risk for pressure ulcers, and had no unhealed pressure ulcers, or any other ulcers, wounds or arterial ulcers on admission.

The initial skin assessment on June 28, 2018 shows R2 had scabbed areas with redness on the shins of both legs. The nursing admission narrative note on June 28, 2018 at 6 PM shows R2 was alert and oriented, had some difficulty with speech, and right sided weakness. On the

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treatment record dated June 28, 2018, the skin check revealed multiple bruises to bilateral upper extremities. "Must monitor bilateral lower extremities, noted areas of scabbing with redness". Skin check daily with weekly charting was initiated on the treatment plan. The risk for skin breakdown assessment score on admission was 15 (high risk).

The treatment record observation notes dated July 5, 2018 states skin for R2 was intact. The nursing notes for R2 on July 16, 2018 states, "Open area on left heel, 7.6 x 4 cm, was discussed with wife. Wife said R2 has had a problem before on his heels, and the foot doctor recommended applying merthiolate and wrapping feet in an ace wrap. The wife said this had worked in the past". The physician order for R2 on July 16, 2018 to apply heel protectors when in bed and to clean wound to left heel twice a day, cover with foam pad and wrap. The wound cleansing treatment started on July 17, 2018 according to the treatment record documentation.

The treatment record observation notes for R2 on July 18, 2018 at 11:00 AM, described the left heel, "A ruddy color with slough. Epidermis of skin has split away, 0.2 cm black core in middle noted". Interventions on the treatment record listed on that day included, no shoes to be worn, heel protectors and elevate heels.

The treatment record observation notes for R2 on July 19, 2018 at 11:00 AM, shows, "Large amount of clear exudate from the left heel site, measured 9 cm x 7.6 cm x 0.01 cm with a 5 cm X 3.5 cm black area. No black core noted, (the) surrounding tissue (is) purple".

On July 20, 2018 a new physician order for R2

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stated to cleanse right heel wound twice a day and cover with foam pad and wrap. The order included to consult the wound clinic for R2. The inital appointment was scheduled for July 26, 2018 and was missed. The appointment was rescheduled for August 2, 2018 (13 days after the initial order).

The Minimum Data Set (MDS) dated July 5, 2018 showed no pressure wounds on admission. The interim care plan dated June 28, 2018 for R2 was not updated to address the wounds and pressure relief interventions to R2's heels. The Care Area Assessment (CAA) on July 5, 2018 showed, "A care plan would be developed related to the information gathered from the resident's chart and (pressure risk) assessment completed on July 9, 2018. The interdisciplinary team will continue to care plan this area, skin checks will be done daily to catch any skin issues early. R1 was identified at high risk related to recent CVA with right side weakness and being chair fast".

The treatment record for July 2018 shows daily skin checks checked off, but no change in R2's skin was noted prior to July 18, 2018 when the wound was found opened and 7.6 cm x 4 cm in size. No wound measurements for the right heel were found in the medical record between July 20, 2018 and August 2, 2018.

The treatment record observation notes for R2 on July 26, 2018 shows, "Both heels open, black tissue in the bed of the wound. The right foot has black tissue on top near the ankle. (The) 3(rd) digit on right foot has 0.8 x 0.6 open area. Plan to see wound doctor today".

On July 28, 2018 the treatment record observation notes for R2 show the "Top of the

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right foot has black area 3.8 cm x 3.2 cm x <0.001 cm area".

On August 2, 2018 at 10:35 AM, V1 (Administrator) stated, R2 missed his appointment to the wound clinic because the driver did not arrive and we did not know until after the appointment time that he was not going. V1 stated appointments are very important part of the resident's recovery and I don't like rescheduling and explaining to the family, physician office and public health about why the resident did not go. V1 stated he spoke with R2's wife about rescheduling the appointment and she told V1 that R2 had a problem in the past with heel sores.

On August 2, 2018 at 10:05 AM, V2 (Director of Nursing - DON) stated R2 had an appointment last Thursday to see the wound doctor. It was missed and he is going today. At 12:15 PM, V2 (DON) stated, "I don't believe this pressure is our fault, something was brewing before he ever got here and my nurses couldn't see it." V2 stated, "Off loading R2's heels is not a good option for him, he is moving his legs constantly. Heel boots are the best we can do." V2 stated they have not attempted any interventions to off load and asked how should the facility have know (his heels were going to open up). V2 did not know why the daily skin checks did not show changes to R2's heels. V2 presented the interim care plan (from admission) and stated she had not had time to develop a new care plan.

On August 2, 2018 at 11:45 AM, V3 (Licensed Practical Nurse - LPN) stated R2's left heel opened up mid July. "It looked like skin peeled off and in the very center, there was a dark black spot." V3 stated on admission, she felt R2's

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heels were dark red, a ruddy color, but the skin was intact. V3 stated at times she tried to roll up a bedspread and put under his legs, but it was hard to keep it there. At 2:45 PM, V3 reviewed the wound notes in R2's medical record and summarized on July 16, the first heel opened up and the treatment was started on July 17. On July 20 the second (right) heel opened. No wound measurements or description of the wound were found. On July 28, R2 developed a red area on the top of the foot that was a dark ruddy color. We covered the top of the foot with a (thick absorbent pad) for more protection. R2 actively moves his legs, but V3 does not recall if R2 crosses his feet. V3 stated, "I reported today that around both heel wounds the skin is very dark red, angry hot looking."

On August 3, 2018 at 11:15 AM, V6 (R2's wife) stated R2 went to the wound doctor on August 2, 2018 and they directly admitted him to the hospital for wound treatments. V6 stated, "The wound doctor reported the heel wounds came from pressure from being in bed and stated the facility should have put pillows under his legs to relieve the pressure. The wounds are in bad shape. The doctor is planning on surgery to clean off the dead tissue and try to save his feet". V6 continued, "The facility should have done more and done it sooner than they did. I had no idea his heel wounds were in such bad shape until I saw them at the clinic".

On August 7, 2018 at 9:48 AM. V8 (Wound physician) stated R2 is still in the hospital. V8 stated offloading is important in prevention of heel decubitus and some pressure relief would have helped prevent the heel ulcers from developing on R2. V8 stated when R2 arrived for the intial consult, the heels had bilateral decubitus and

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S9999	Continued From page 8 required immediate treatment in the emergency room, hospitalization and surgery. The hospital admission record dated August 2, 2018 shows R2 was a direct admit from the wound clinic with bilateral heel necrosis. The inpatient orthopedic physician assessed R2's heel as pressure ulceration with necrosis (unstageable) bilateral posterior heels, cellulitis bilateral heels. The hospital plan includes intravenous antibiotic, strict elevation of the heels with pillows under calves, and dressing changes by the wound care team. R2 will need extensive debridement of bilateral heel ulcers and plans for surgery on Sunday. The facility policy for decubitus care/pressure areas dated 05/07 states to 2) the pressure area will be assessed and docmented on the treatment administration record. 3) i) To document the size, stage, site, depth, drainage, color, odor and treatment. 5) Documentation of the pressure area must occur upon identification and at least once each week on the treatment adminstration record. 8) Initiated propblem on the care plan. The policy does not include information related to interventions for pressure relief prior to or after the development of a pressure wound. (A)	S9999		