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S 000	Initial Comments Complaint 1865274\IL104919	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)3)4)A)5) 300.3220f) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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:

A) Each resident shall have proper daily personal

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attention, including skin, nails, hair, and oral hygiene, in addition to treatment 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.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidence by:

Based on interview and record review the facility failed to provide nutritional interventions and treatment to promote pressure ulcer healing for a resident. This failure affects one of four (R1) residents reviewed for pressure ulcers in a

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sample of four. This failure resulted in R1's sacral pressure ulcer increasing in size with worsening characteristics (odor, drainage).

Findings include:

R1's Physician's Order Sheet (POS) for August 2018 documents that R1 was admitted 7/23/18 with the following diagnoses: Dementia and Sacral Decubitus Ulcer. R1's admit Care Plan initiates skin risk or pressure ulcers, then the problem and interventions were added dated 8/7/18.

R1's wound assessment from the hospital dated 7/18/18 documents R1 was admitted to the facility from home with one Stage III decubitus ulcer to R1's left sacrum measuring 2.4 cm (centimeters) length(L) by 0.8 cm. width(W) by 0.1 cm depth(D). Wound bed covered with necrotic slough and poorly defined wound edges. No odor small amount serous (clear) drainage and one Stage I decubitus ulcer to R1's right sacrum measuring 2.5 cm L by 1.2 cm. W by 0.1 cm D. Wound bed covered with necrotic slough and poorly defined wound edges. No odor, small amount serous (clear) drainage. This area was documented as healed by 7/23/18. R1's wound assessment from the hospital dated 7/23/18 documents R1 was transferred to the facility with one decubitus ulcer to R1's left sacrum measuring 0.5 cm L by 0.5 cm. W by 0.1 cm D. Wound bed covered with necrotic slough and poorly defined wound edges. No odor or drainage. Wound photographs dated 7/18/18 and 7/23/18 support this assessment.

On 8/14/18 at 9:00 AM V4, Registered Nurse (RN) Certified Wound Care Nurse (CWCN) hospital staff stated "I assessed the wound on

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(R1's) Left sacrum 7/23/18 (as above) prior to R1's discharge to (the facility) The Stage II pressure area to (R1's) right sacrum had closed by that time."

R1's "Nursing Admission Assessment" dated 7/23/18 (not timed) by V5, Licensed Practical Nurse (LPN) documents "pressure areas" on an anatomical drawing of R1 on the left side of the sacrum labeled "1.5cm open" and one on the right side of the sacrum labeled "gray decub(decubitus) 2cm." R1's assessment did not document wound characteristics shape, depth, wound bed appearance, presence of any drainage, or appearance of surrounding tissue. A progress note dated 7/23/18 at 3:45PM also by V5 states (R1's) "Buttocks 3 areas #1.) 1.5cm shear left inner #2.) 0.5cm not open #3.) 2cm rt. inner gray in color."

R1's hospital discharge summary by V9 Family Nurse Practitioner (FNP) dated 7/23/18 at 11:47AM documents "'Foley catheter was placed again. (R1) should follow-up with urology in one week upon discharge." R1's progress note dated 7/25/18 at 11:15AM documents "called (primary physician) and got order to remove catheter. Removed at 11:05AM." R1's Nursing Care Observation report documents 7/26/18 through 7/28/18 Incontinent of Bowel and bladder. R1's Physician's Orders document on 7/28/18 cleanse intergluteal cleft with (peri care solution) apply calc.(calcium) alg.(alginate) cover with hydrocellular foam and dry dressing.

On 8/14/18 at 11:10AM V2, Acting Director of Nursing (DON) stated "considering the wound care it was probably not a great idea to take out (R1's) catheter. It (the catheter) was only out a few days." R1's Physician's Orders dated 7/30/18

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document catheter was reinserted.

R1's dietary assessment dated 7/25/18 by V10, Dietary Manager documents R1 "feeds self with set-up" This document also states "Diet Order: Regular/No Added Salt/ Med-Pass 120 Milliliters BID (twice daily)/Multiple Vitamin with Minerals/Prostat (protein supplement) 30 Milliliters BID (twice daily)." R1's Minimum Data Set (MDS) dated 7/30/18 documents R1 as requiring only set-up and supervision for eating. R1's Medication Administration Sheet for August 2018 documents that Multiple Vitamin with Minerals/Prostat was not initiated until 8/7/18. R1's hospital "discharge summary" dated 7/23/18 documents R1's albumin as "3.6" which is within the normal range. R1's hospital note dated 8/7/18 documents R1's albumin as "2.3 low." Mayo Clinic laboratory web site states a common cause of low albumin is "due to diminished protein intake(and) "as a result of tissue damage and inflammation."

R1's Initial Wound Evaluation & Management Summary documents on 7/25/18 (no time listed) V11, Medical Doctor, facility contracted wound care, saw R1 at the facility. V11 completed a wound debridement. V11 documented "Stage II pressure ulcer right buttock wound size: (Length by Width by depth) 2.1 by 1.0 by 0.1 cm. (centimeters) with light serous exudate (drainage). Unstageable (due to necrosis) pressure ulcer left buttock wound size: (Length by Width by depth) 2.0 by 1.0 by 0.1 cm. (centimeters) with light serous exudate (drainage) and 30% slough (nonviable tissue). The plan documented by V11 at this visit was for R1 to see wound care specialist in seven days.

R1's medical record documents on 8/2/18 at

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S9999	Continued From page 6 1:50PM V2, acting Director of nursing documented "(primary physician) was in and did not feel an antibiotic would help and wanted to make an appointment with wound clinic at (local hospital)." There is no documentation that this appointment was made nor reason for not scheduling. R1's Nurses Notes document the following: On 8/3/18 at "12a" V12, Licensed Practical Nurse (LPN) documented "Stage III to coccyx with thick purulent drainage, foul odor." On 8/3/18 at 8:30AM V13, Advanced Practice Registered Nurse (APRN) documented "patient has a large decubitus ulcer to coccyx last week debrided by the wound doctor who is now on vacation." V13 also documented "Patient has open area 6cm by 6cm (no depth measurement) to coccyx." V13 ordered a wound culture at that time which V13 obtained and sent to lab. On 8/8/18 at 10:45AM V5, Licensed Practical Nurse (LPN) documented "at approximately 9:15AM therapy called this nurse to (R1's) room. (R1) color was ashen, skin warm, (R1) was short of breath and had some clonic jerking." R1 was sent to the hospital at that time and expired 8/11/18. On 8/8/18 at 5:23pm, V4, Registered Nurse (RN) Certified Wound Care Nurse (CWCN) hospital staff documented in R1's hospital record "Unstageable pressure injury with significant periwound deep tissue injury noted to patient's coccyx. The open area of skin measures approximately 7 cm by 5cm by 0.1cm. (length by width by depth) There is a small amount of purulent drainage noted on the dressing with a faint odor. The wound margins are poorly defined. The wound bed is completely covered with soft yellow, brown slough." Wound	S9999		

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photographs dated 8/8/18 support this assessment.

On 8/14/18 at 9:14 AM V4, Registered Nurse (RN) Certified Wound Care Nurse (CWCN) from the hospital stated "In my opinion the significant decline in this wound was caused by frequent pressure to to (R1's) coccyx over time."

On 8/14/18 at 9:18AM V7, Advanced Practice Registered Nurse (APRN) hospital staff completed R1's history and physical in the emergency department 8/8/18, stated "While (R1) did have comorbidities, I believe that the decline in the decubitus ulcer to (R1's) coccyx was caused by pressure and could have been avoided if (R1) had been turned and positioned regularly while at the facility. The lack positioning, in my opinion, caused irreparable harm to this patient (R1).

On 8/14/18 at 11:10AM V2, acting Director of Nursing stated "I know we didn't do a good job documenting (R1's) wound and it did get worse."

The facility's policy "Decubitus Care/Pressure areas last revised 5/2007 states "Policy: To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. This policy also states "Documentation of the pressure area must occur upon identification and at least once each week on the Treatment Administration Record. (TAR) The assessment must include: Characteristic (i.e. size, shape, color, presence of granulation tissue, necrotic tissue, etc.) Treatment and response to treatment." The facility's policy "Skin Condition Monitoring" last revised 11/1/12 states "Documentation of skin abnormality must occur

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S9999	Continued From page 8 upon identification and at least weekly thereafter until the area is healed. documentation of the area must include the following: Characteristic 1. Size 2. Shape 3. depth 4. color 5. presence of granulation tissue or necrotic tissue. Treatment and response to treatment." A	S9999		