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S 000	Initial Comments Complaint Investigation #1816322/IL106082	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)3)4)A)5) 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 meet the resident's medical, nursing, and mental	S9999	Attachment A Statement of Licensure Violations	

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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.

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 attention, including skin, nails, hair, and oral

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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 300.3240 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 observation, interview and record review the facility failed to implement pressure relieving interventions for a resident with a Stage 2 pressure injury and for residents at risk for pressure injuries. The facility failed to ensure a pressure injury wound treatment was completed in a manner to prevent cross contamination. The facility failed to ensure residents' skin was kept free of biological irritants. These failures resulted in a resident's (R2) Stage 2 pressure injury declining to a unstageable pressure injury with a diagnosis of osteomyelitis.

This applies to 3 of 3 residents (R1-R3) reviewed for pressure injuries in a sample of 4.

The findings include:

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1. R2's Resident Face Sheet printed September 26, 2018 showed R2 was admitted to the facility on July 9, 2018 for rehabilitation after sustaining a fall which resulted in a right femur fracture.
R2's Minimum Data Set (MDS) dated July 16, 2018 showed that R2 was cognitively intact and required extensive assistance of 2 staff for bed mobility and toileting.
R2's Wound Assessment Report dated July 10, 2018 showed R2 had a Stage 2 pressure injury to R2's coccyx measuring "0.6cm x 0.2cm x 0". The report also showed there were no signs of infection to R2's coccyx wound. The report does not show any wounds to R2's right heel.
R2's Wound Assessment Report dated July 18, 2018 showed R2's coccyx wound measurements had increased to "3.0cm x 1.5cm x unknown". The report also showed R2 had developed a new pressure injury to R2's right heel measuring "2 x 2 x 0".
V7's (WNP) Wound Provider History and Physical Report for R2 dated July 25, 2018 showed, "I was asked to see this patient due to a worsening sacral wound...Wound nurse reports that the wound is deteriorating. This wound illustrates various levels of deterioration..." The report showed R2's wound to measure "11cm x 10cm x 0.1cm"
R2's Wound Assessment Report dated August 7, 2018 showed R2's coccyx pressure injury was as an unstageable wound. R2's right heel wound measurements had increased to "3cm x 4cm x unknown".
R2's coccyx X-ray report dated August 9, 2018 showed, "Slight reactive bone changes at the posterior access of the coccyx in close proximity to the wound, suspicious for osteomyelitis..."

On September 26, 2018 at 9:45 AM, R2 was lying

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on R2's back in bed with a wound vacuum in place to R2's buttocks. R2 stated, "I got this wound vacuum after I got here because the wound on my butt got worse. I also have a sore on my right heel that is new... I probably got it (coccyx wound) because I laid in my poop a lot. They don't always clean you up quickly..." When R2 was asked why R2 had an intravenous needle (IV) in R2's right arm, R2 stated, "I got an infection somewhere and need antibiotics...I think it might be in the wound in my butt..."

On September 26, 2018 at 10:50 AM, R2 was repositioned on R2's right side, in bed, by V11 Registered Nurse (RN) and V12 Wound Nurse, R2 was incontinent of a moderate amount of stool with stool noted up between R2's buttocks, directly below R2's coccyx pressure wound, and on R2's incontinence brief. V12 attempted to tuck R2's soiled incontinence brief under R2's right hip but a piece of the brief, soiled with stool, was placed directly next to R2's wound. Without providing incontinence care and removing R2's soiled incontinence brief, V12 proceeded to remove R2's wound vacuum and wound dressing from R2's coccyx wound. V12 then continued to place a new wound dressing and reattach the wound vacuum to R2's wound while R2 was positioned on top of the brief soiled with stool.

On September 26, 2018 at 11:25 AM, V12 Wound Nurse stated, "I don't know why (R2) wound (coccyx) got so bad...Yes, (R2) has been on IV antibiotics forever because of the osteomyelitis from R2's wound."
On September 27, 2018 at 1:00 PM, V12 Wound Nurse stated, "I asked (V7 WNP) to see (R2) on July 24, 2018 because I felt like someone needed to see (R2) while (R2's) wound physician was gone on vacation. On August 8, 2018, (V7 WNP)

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S9999	Continued From page 5 told me (V7) suspected (R2) had osteomyelitis." On September 26, 2018 at 12:15 PM, V7 WNP stated, "I was asked to see (R2) by (V12 Wound Nurse) because (R2) had some concerns about R2's coccyx wound and (R2's) physician was gone. (R2's) coccyx wound went south really fast. I don't know why. Yes, when (R2) was admitted it was originally a Stage 2 but it got worse fast and (R2) developed osteomyelitis. (R2) also developed a pressure wound to (R2's) right heel in the facility...If a resident is incontinent, incontinence care should be provided before changing a wound dressing to avoid contamination." R2's Physician Order Report dated July 18, 2018 showed, "low air loss mattress". On September 26, 2018 at 12:45 PM, V2 Director of Nursing (DON) was asked why R2 was not placed on a low air loss mattress on R2's admission to the facility on July 9, 2018. V2 stated, "If a resident is admitted with a Stage 2 pressure injury or higher, they get a low air loss mattress. I'm not sure why (R2) was not put on one when (R2) was admitted." 2. R1 was unavailable for observation as R1 was discharged from the facility on August 4, 2018. R1's Physician Order Report dated July 12, 2018 showed R1 was admitted to the facility on July 12, 2018 with diagnoses including cerebral infarction which resulted in R1 being aphasic with a right sided hemiplegia and hemiparesis. R1's Care Plan dated August 2, 2018 showed R1 "required maximum to extensive assistance" with all ADL's (activities of daily living) including toileting and repositioning. The Care Plan also	S9999		

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showed "anticipate (R1's) needs - frequent repositioning, incontinence care" and "provide incontinence care after each incontinent episode..."
R1's Skin Risk Assessment dated July 13, 2018 showed R1 was at very high risk for developing a pressure injury.
R1's Skin Observation Report dated July 15, 2018 showed no open wounds to R1's buttocks.
R1's Progress Note dated July 16, 2018 showed, "WCN (wound care nurse) notified spouse and daughter ..... of wound to bottom that was found today..."
R1's Wound Provider History and Physical Note dated July 18, 2018 showed, "During (R1's) stay at the (facility), the patient developed a DTI (deep tissue injury) of the sacrum." The Provider Note also showed R1 had a wound to (R1's) sacrum measuring "5.5cm (centimeters) x 3.0cm x 0)".
R1's Wound Provider History and Physical Note dated August 1, 2018 showed that R1's "sacral wound is deteriorating...." R1's sacral wound measured "6cm x 5cm x 0.1cm". The Provider Note showed that R1 had also developed a "new area of incontinence associated skin damage..." to (R1's) perianal area.

On September 25, 2018 at 11:30 AM, V4 (Daughter of R1) stated, "My dad had no wounds to (R1's) buttocks until after (R1) got to the facility. (R1) was in there just 4 days when the nurse told me that dad developed a small blister to (R1's) buttocks. It wasn't a small blister, it was the size of a softball...Maybe it (wound) happened because my dad always had diarrhea and laid in poop. I always had to find staff to come clean dad up..."

R1's Physician Order Report dated July 16, 2018 showed, "Low air loss mattress." On September

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27, 2018 at 10:55 AM, V12 Wound Nurse stated, "(R1) had no pressure wounds when (R1) was admitted. I'm not sure how it (R1's sacral wound) developed or why it got so bad." When V12 was asked why R1 was not placed on a low air loss mattress until after R1 developed the wound to R1's sacrum (on July 16, 2018), V12 stated, "I don't have a good answer for that. I'm not really sure why we didn't. I guess I didn't realize or underestimated how immobile (R1) was."

On September 26, 2018 at 12:15 PM, V7 Wound Care Nurse Practitioner (WNP) stated, "Anything that causes you to be immobile, like a stroke or someone who is a postsurgical hip fracture, puts you at risk for a pressure injury. If a resident is high risk for pressure injuries or if a resident is admitted with a pressure injury, ideally they should be placed on a low air loss mattress upon admission to the facility...Yes, (R1) was admitted to the facility without any pressure injuries...I am not sure how (R1) wound developed... Frequent repositioning, turning, and incontinence care is key to preventing new wounds and the worsening of previous wounds for these residents. Repositioning and frequent incontinence care should be provided at least every 2 hours."

3. R3's Resident Face Sheet printed September 26, 2018, showed R3 was admitted to the facility on September 3, 2018 with diagnoses including a cerebral infarction with left sided hemiplegia and hemiparesis.
R3's MDS dated September 10, 2018 showed R3 required extensive assistance of 2 staff for bed mobility and toileting.
R3's Skin Risk Assessment dated September 3, 2018 showed R3 was at a high risk for developing pressure injuries.
R3's Care Plan dated September 5, 2018 showed

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S9999	Continued From page 8 R3 was at risk for skin breakdown. The Care Plan showed, "Provide incontinence care after each incontinent episode." On September 26, 2018 at 9:45 AM, R3 was lying on R3's back in bed. V15 (Daughter of R3) was seated next to R3. V15 stated, "I have a concern. (R3) has been here for 3 weeks. I have been times when (R3) has laid in (R3's) poop and pee for up to an hour....There has also been times when (R3) has been sitting in (R3's) wheelchair for hours...(R3) is always on (R3's) back. I have never even seen them offer to reposition (R3) ..." On September 26, 2018 at 10:30 AM, R3 was in bed, asleep on (R3's) back, with V15 at bedside. On September 26, 2018 at 11:15 AM, , R3 was in bed, asleep on R3's back, with V15 at bedside. On September 26, 2018 at 11:40 AM, V13 and V14 CNA's provided R3 with incontinence care. V14 repositioned R3 on R3's right side, as V13 removed R3's incontinence brief as R3 was incontinent of urine. R3 had long linear marks to both buttocks with redness and excoriation to the skin between R3's buttocks. V14 CNA stated, "Those marks on (R3's) buttocks are from the creases in (R3's) brief or from (R3's) bedding. (R3) has been laying on (R3's) back for awhile." V14 CNA stated V14 last provided R3 with incontinence care at 8:15 AM on September 26, 2018. On September 26, 2018, V2 DON, V9 CNA, and V10 RN, each stated incontinence care and repositioning should be provided for residents every 2 hours. The facility's Pressure Ulcer Prevention Program Policy (undated) showed the facility "shall provide care, treatment, and services to: promote the prevention of pressure ulcer development,	S9999		

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S9999	Continued From page 9 promote the healing of pressure ulcers that are present, prevent development of additional pressure ulcers...Preventive interventions for all patients at risk:...Use pressure redistribution devices, i.e.,...low air mattresses...Keep linen wrinkle-free to prevent uneven pressure distribution...Try to prevent any moisture, diarrhea, urinary incontinence and sweating because excretions may cause skin maceration..." (A)	S9999		