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	IL6005904	A. BUILDING: _____ B. WING _____	R-C 12/27/2019

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WINDSOR ESTATES NSG & REHAB	18300 SOUTH LAVERGNE COUNTRY CLUB HILLS, IL 60478

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{S 000}	Initial Comments First Certification Complaint Follow-up to 11/06/2019 1996522/ IL115456 1996801/ IL115761	{S 000}		
{S9999}	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a) 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. 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	{S9999}	Attachment A Statement of Licensure Violations	

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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:
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. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to have an individualize resident care plan addressing pressure relief or repositioning, avoiding excessive moisture to areas at risk for development of pressure ulcers; changes in nutritional therapy needed to prevent

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development of pressure ulcers; failed to promptly identify and treat newly developed pressure ulcers before progressing to stages three and four; and failed to have evidence of wound doctor's recommendations being followed to help treat and heal existing pressure ulcers for 1 of 4 residents (R2) reviewed for pressure ulcers.

These failures resulted in R2 developing two new pressure ulcers which were not identified and treated prior to becoming unstageable and later developing a left buttock stage 3 pressure wound and a right buttock stage 4 pressure wound.

Findings Include:

R2 was admitted to the facility on 08/02/19 with diagnoses including: Rhabdomyolysis, Encephalopathy, Need for Assistance with Personal Care, Acidosis, Acute Kidney Failure, Dementia, Type 2 Diabetes Mellitus, Essential (Primary) Hypertension and Anemia.

R2's MDS assessments dated 9/03/2019 and 11/09/2019 indicated R2 had no pressure ulcer/injury and R2 is at risk for pressure ulcer/injury. The 11/09/2019 MDS assessment did not indicate turning or repositioning for treatment.

R2's MDS (Minimum Data Set) assessment dated 12/06/19 indicated the resident had severely impaired cognition, required extensive assistance with toilet use and personal hygiene, was frequently incontinent of urine and bowel, had a weight loss, and had two unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. Skin and ulcer/injury treatments included pressure reducing device for chair, and nutrition/hydration intervention. No

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turning or reposition was indicated for treatment.

Weights and vitals summary indicated indicate a weight loss of 5% on 8/28/2019, 7.5% on 10/4/2019 and 10% on 12/14/2019.

On 12/26/19 at 09:34 AM R2 was observed in bed requiring assistance to be turned by the wound care aide for wound dressing change. R2 was observed to have a stage 3 wound to the right buttock and a stage 4 wound to the left buttock. On 12/26/19 at 09:36 AM V5 (Registered Nurse/Wound Nurse) stated, "R2's wounds were facility acquired. He has a poor appetite. The right buttock wound is a stage 3 and left buttock wound is a stage 4."

On 12/26/19 at 03:25 PM V5 stated, "I did the measurement for R2's wound. Initially the surface was all classified as one wound. The tissue was necrotic (brownish in color). It looked like a shearing brown and I could see drainage. R2 is incontinent. The wound care doctor debrided and reclassified the wound."

On 12/26/19 at 04:00 PM V3 (Chief Operating Officer) stated, "With each shower or bed bath the nurse is to do a skin assessment. If someone is under-nourished they are at risk for skin alterations."

On 12/27/19 at 11:27 AM V12 (Physician) stated, "Wound development can vary from patient to patient depending on their nutrition. R2's nutrition was a factor. The prealbumin (indicator of protein stores) that was done in November was low at 14.6 and is an indicator for nutritional status. That can contribute to wound development as well."

On 12/27/19 at 12:50 PM V14 (Wound Care

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Physician) stated, "When I saw R2's wound it was necrotic (dead tissue) and required debriding. I had to keep debriding the wound because the necrotic tissue was not all gone. Continued pressure causes further damage if not offloading. It is not likely that the wound happened in one day. It could have been a DTI (Deep Tissue Injury) that progressed. (R2) is severely malnourished and residents who are nutritionally compromised are at high risk for skin breakdown. The poor appetite could have contributed to the wound developing as well as not off loading and repositioning. Skin issues should be identified for incontinent patients. R2 had a bridge of normal skin so I debrided the wound because of the necrotic tissue and it was reclassified as a stage 3 wound to the right buttock and a stage 4 wound to the left buttock. It was some normal skin mixed but mostly necrotic and one was pretty deep. It would have remained unstageable until I could see the wound base."

On 12/27/19 at 01:46 PM V13 (Licensed Practical Nurse) stated, "On 12/02/2019 V15 (Certified Nurse Assistant) came to me and said there is something on R2 buttocks; a rash or burn. I checked the progress note and did not see any documentation about it. (R2) had an open wound on his buttocks when I checked him. It was black in the middle of the sacral area."

On 12/27/19 at 02:09 PM V10 (Licensed Practical Nurse) stated, "I had not ever seen any wounds on R2 buttocks. I can't recall taking care of R2, but he is always in the chair."

Progress note dated 12/02/19 08:38 AM written by V13 (Licensed Practical Nurse) reads in part, "Patient noted with open skin on buttocks area."

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Progress note dated 12/02/19 10:58 AM written by V5 (Registered Nurse/Wound Nurse) reads in part, "Alerted by floor nurse to resident room to evaluate pressure wound to sacrum. Unstageable pressure ulcer noted to sacrum 6.5 x 8.5, necrotic tissue present, scant drainage, no odor."

Wound Physician note dated 12/03/19 written by V14 (Wound Care Physician) reads in part, "Patient with reported poor p o (by mouth) intake, ongoing weight loss. Unstageable left buttocks: with clean surgical technique, curette was used to surgically excise 16.5 cm (Centimeters) of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissue were removed at a depth of 0.2 cm. Unstageable right buttock: with clean surgical technique, curette was used to surgically excise 31.5 cm of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissue were removed at a depth of 0.2 cm. Recommendation: Low air loss mattress; off load wound and reposition per facility protocol."

Wound Physician note dated 12/10/19 reads in part, "At risk for wound decline and new wound development in face of nutritional compromise, recommend limit sitting to up for meals and therapy only. Left and right buttock debrided, left classified as unstageable and right buttock classified as stage 4 pressure wound. Recommendations: low air loss mattress; off-load wound, reposition per facility protocol and limit sitting to up for meals and therapy only."

Wound Physician note dated 12/17/19 indicate left and right buttock debrided, left classified as a stage 3 pressure wound and right buttock classified as stage 4 pressure wound. Recommendations: low air loss mattress, off-load wound, reposition per facility protocol and limit

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sitting to up for meals and therapy only.

R2's lab results dated 11/13/2019 indicated a low prealbumin (indicates protein level in blood) of 14 (reference range 18-35.7 MG). There were no additional labs available to measure available protein stores to maintain adequate nutrition and wound healing for R2 since that date.

R2's Active orders as of 12/24/2019 indicated the following:
Up in chair daily and as needed/as tolerated: order date of 8/02/2019.
Megestrol Acetate Suspension (appetite enhancer) 400 mg (milligram): order 11/29/2019
Vitamin C 500 mg daily: order date 12/05/2019
Multiple Vitamins-Minerals 1 tab daily: order date 12/05/2019

Diet order: No added salt/low concentrated sweets diet with fortified mashed potato for lunch and dinner, super cereal for breakfast. Milk with every meal and health shake at lunch and dinner: order date 8/02/2019.

House supplement 120cc (cubic centimeter) 3 times a day with order date 11/29/19 and Liquid protein supplement two times a day 30 ml twice at day date order 12/03/2019

Laboratory orders included prealbumin and albumin with order date of 12/11/19.

Care plan interventions prior to the identification of the pressure ulcer included but were not limited to:

R2's care plan for pressure ulcer development related to disease process/immobility dated 8/05/2019 included the following interventions:

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resident requires the bed as flat as possible to reduce shear. Educate the resident/facility/care givers as to causes of skin breakdown and teach resident/family the importance of changing positions for prevention of pressure ulcers.

Care plan for diabetes dated 8/14/2019 included interventions to check all of body for breaks in skin and treat promptly as ordered by the doctor.

Care plan for incontinence dated 8/05/2019 included interventions including: clean peri-area with each incontinence episode.

Care plan for nutrition last dated 10/03/2019 with intervention dated 8/08/2019 includes: Discuss food preferences, explain and reinforce to the resident the importance of maintaining the diet ordered, provide and serve diet as order, dietitian to evaluate and make diet change recommendations and weigh at time of day and record per facility protocol.

The first nutritional intervention for the low protein level came 2 weeks after the labs results, and the rest were implemented at the time the new pressure ulcers were identified. There were no changes to the resident's care plan for nutritional therapy and no plan to monitor for food intake or the effectiveness of the nutritional therapy.

The care plan does not outline what preventive interventions or actions the nursing staff utilized to relieve pressure while the resident was in bed or wheelchair; any use of pressure relief devices; how the resident would be kept clean and dry throughout the day; and turning/positioning a resident with a low cognitive status and dependent on staff for activities of daily living (ADLs).

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Shower sheet documents the nurse is to perform skin checks during resident's bath and shower days. R2 has no documented skin checks on shower days 11/23/19, 11/26/19 or 11/30/19.

(B)