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	IL6011381	A. BUILDING: _____ B. WING _____	C 11/25/2020

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S 000	Initial Comments 2078748/IL128395- F684 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

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 Regulations were not met as evidenced

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S9999	Continued From page 2 by: Based on interview and record review, the facility failed to assess, document and treat a resident's (R1) post-surgical wound on the left hip (Hip Arthroplasty). This failure resulted in the wound becoming infected (Infected left total hip arthroplasty) requiring the resident to be hospitalized and undergo a surgical procedure due to the infection and receive antibiotic therpy. This applies to 1 resident (R4) reviewed for wound care. The findings include: Facility's Wound Treatment Guidelines showed: Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standard of practice and physicians order. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician's orders, including cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the license nurse will notify the physician to obtain treatment orders. This may be the treatment nurse or the assigned licensed nurse in the absence of treatment nurse. R4's face sheet showed that R4 is an 80 year-old who admitted to the facility on 9/18/20 and has multiple medical diagnoses which includes,	S9999		

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aftercare following joint replacement surgery and presence of left artificial hip joint. R4's Minimum Data Set (MDS) dated 9/25/20 showed that R4 is alert and oriented.

Hospital Record (Prior to Facility's Admission 9/15/20-9/18/20) showed that R4 a had left total hip arthroplasty on 9/15/20 and was discharged to the facility on 9/18/20. It also indicated multiple instructions which includes, keeping the wound clean and dry, changing the dressing in one week, following up with physician as directed in 2 weeks and suture/staple removal in 2 weeks.

Facility's admission notes dated 9/18/20 showed: R4 was admitted from the hospital after a recent left hip arthroplasty. R4 is alert and oriented to name, time, place and situation. R4 complained of pain in the left hip but is managed well with her Norco.

R4's Care Plan showed: R4 has a Left hip fracture related to fall.
Goal: R4's surgical incision will heal without signs and symptoms of infection or breakdown by review date.
Intervention: Monitor/document/report as needed for signs and symptoms of hip fracture complications such as contracture formation, embolism signs and symptoms (cyanosis, pain, petechiae, increased heart rate (Tachycardia), tachypnea, difficulty breathing (Dyspnea)), infection at surgical site, impaired mobility, unrelieved pain, Pneumonia/poor air exchange, incontinence.

R4 stated on 11/17/2020, that two days before she was sent out to the hospital, that she reported to the nursing staff that her wound was leaking and bleeding. R4 stated that she cannot

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S9999	Continued From page 4 recall who she spoke with regarding her wound. R4 added that on10/14/2020 she again reported to the nursing staff that her wound was bleeding and that later that day she went to see her own doctor and was admitted to the hospital for wound care. R4's skilled nursing notes and assessments from 9/19/20 through 10/13/20 does not have any evidence of documentation of wound assessment, there was no description of the wound whether the wound was healing or deteriorating. There was only one documentation in the nursing notes dated 10/6/20 which showed that the staples from left hip incision were removed, incision was well approximated and pink/healthy. Another documentation in the weekly skin observation notes dated 10/9/20 indicated that the surgical incision was covered by bandage. However, there was no further follow up documentation about the surgical site. There was no evidence of documentation with regards to following up with physician related to post-surgical wound management. A nursing note on 10/14/20 at 5:40 AM showed, that R4 approached V10 (Nurse) asking for a shower before her appointment. R4 had sero-sanguinous drainage dripping down the left leg. R4 assisted to the shower. The steri-strips were wet with drainage. There was a small purple hematoma under top fold of left hip and abscess to lower incision with purulent drainage. The area was cleansed, and foam dressings applied. Bed sheets were changed that were soiled with drainage. In addition, there was no site of administration found in the treatment administration record (TAR) related to wound care.	S9999		

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S9999	Continued From page 5 On 11/17/20 at 1:36 PM, V3 (LPN/Wound Care Nurse) stated, she (V3) had never assessed R4's wound or changed her dressing because R4 was being seen by her orthopedic surgeon at an outpatient clinic. On 10/6/20, R4 had an orthopedic appointment and her staples were removed. It said in the note that the incision was well approximated and pink/healthy. V3 also stated that she works full time in the unit/floor and only does wound rounds with the physician every Friday. V3 added, the floor nurses should be monitoring the residents with wounds and document their assessments. When R4 was admitted from the hospital, her wounds should have been monitored/documented for any signs of drainage, pain or signs and symptoms of infection. On 11/17/20 at 1:45 PM, upon review of R4's documentation, V3 stated/confirmed that there was not an assessment of the wound. V3 added, "it doesn't look like wound has been monitored". On 11/18/20 at 4:17 PM, V2 (Director of Nursing/DON) stated that when nursing staff admit a resident in the facility with post-surgical wound the staff is expected to follow up orders, do a baseline documentation of the wound. Usually when there's order not to open a wound dressing until seen by the follow up physician, the staff should document the condition of surrounding skin/area of the wound. On 11/18/20 at 4:46 PM, V6 (Medical Doctor) gave the following statement: "It is basic knowledge that when a post-op patient goes to rehab, the staff should monitor the condition of the wound. Change the dressing when it is needed. Even when the staples/sutures were removed the staff should continue to monitor it. That's why R4 went there not just for the therapy	S9999		

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but also for the wound. A surgical wound has the potential to develop infection. However, had they (facility staff) been monitoring the wound, it would have been caught early, but it was caught late. It could have been addressed a little sooner. The change of the wound condition in two weeks since the staple removal was drastic. That infection did not develop right away. It could have started about 3 days prior to V6 seeing R4 (on 10/14/20). R4 even told V6's staff that her wound started bleeding a few days prior to being seen."

Hospital Record dated 10/15/20 showed:

Pre-operative diagnosis: Infected left total hip arthroplasty.

Post-operative diagnoses:
1. Infected left total hip arthroplasty.
2. Trochanteric avulsion.

Indications: On R4's first post-operative visit approximately 2 weeks after surgery (left total hip arthroplasty on 9/15/20), her wound looked fine and the sutures were removed. R4 was at the facility. On 10/14/20, V6 (Orthopedic Doctor) received a call that the wound was looking bad. Facility staff brought R4 in for evaluation. R4 had obvious pus coming out with bullae formation and just a very bad-looking wound. V6 immediately admitted V4 in the hospital and felt that R4 needed to be brought to the operating room for the above mentioned procedure. V6 explained to R4 this was obviously a setback and she would need some antibiotics.

Infectious Disease Consultation note dated 10/16/20 showed: R4 reported that there was some pus and bleeding from the wound a few days before visiting V6. On 10/15/20, V6

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S9999	Continued From page 7 performed incision and drainage of the left hip with extensive debridement. V6 also performed a partial excision of the greater trochanter with direct repair of the gluteus medius to the remaining trochanter. Upon admission, R4's white blood cell (WBC) was 10,400 per microliter and rose to 25,900 the next day (indicating infection). R4's Erythro-sedimentation rate (ESR) was 120 (normal for females is 0-29, elevated level indicates possible infection). R4 was started on a antibiotic Vancomycin IV, (Intravenous route). V6 performed wound cultures prior to surgery. Wound cultures results showed Methicillin-resistant Staphylococcus Aureus (MRSA). (A)	S9999		