Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008825	A. BUILDING: ______ B. WING ______	C 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

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S 000	Initial Comments Complaint 2083101/IL122244 - F686 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5) 300.1220b)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,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain 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 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 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. Restorative measures shall include, at a minimum, the following procedures:	S9999		

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S9999	Continued From page 2 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: 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.	S9999		

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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 by:

Based on Record Review and Interview the facility failed to provide accurate pressure ulcer assessments and place preventive measures on plan of care with interventions for the sacral pressure ulcer to 1 resident (R3) reviewed for pressure ulcer assesments.

These failures resulted in a R3's Facility aquired sacral pressure ulcer deteriorating and increased in size.

Findings includes:

R3 was 81 years old, originally admitted to the facility on 3/18/2020 with diagnosis of Stroke, Seizure and Dementia. Interview for Mental Status (BIMS) dated 3/24/2020 reads that R3 has a score of 9 meaning that R3's cognition was not fully intact. R3 was discharged on 4/2/2020.

On 12/1/2020 at 2:45 PM, V9 (Wound Care Coordinator / LPN) stated, "On 3/26/2020, a staff nurse informed me that R3 had an open area on the back side, when I assessed R3 I saw an open blister, bright red, no exudate, no drainage. I informed V10 (Nurse Practitioner) because she was in-charge of R3's medical care including wound treatment. Preventative measures should include turning and repositioning every 2 hours,

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low air loss mattress, ensuring that R3 was not soiled or wet every 2 hours. All of these interventions must be included in the care plan. R3's pressure ulcer on the sacrum was facility acquired."

On 12/2/2020 at 11:10 AM., V3 (Assistant Director of Nursing) stated, "R3 came to the facility due to stroke and needed therapy. R3 had C. Diff. and diarrhea, R3's sacral pressure ulcer most likely worsened from the diarrhea. Proper interventions should be low air loss (LAL) mattress, lab draw, turn and reposition Q2H, making sure resident is clean and dry every Q2H. All of these interventions should be in the care plan and should be included in the physician order. I was not aware that there were no physician orders or care plan done related prevention of the wound from deteriorating. R3 went home per family's request."

Facility provided R3's 2 wound assessments dated 3/26/2020 and 4/1/2020.

Wound assessment dated 3/26/2020 reads: the wound was located on the sacrum, classified as blister, facility acquired, wound size in centimeter (cm) 8.00 X 9.00 X 0.00 (length x width x height), skin intact 50%, bright pink or red 50%, in the photo the wound was open and covers only the tail bone or sacral area.

Wound assessment dated 4/1/2020 reads: the wound was located on the sacrum, classified as blister, facility acquired, wound size in centimeter (cm) 7.00 X 7.50 X 0.00 (length x width x height), bright pink or red 100% and in the photo the wound covers not only the tail bone or sacrum but also a large area of the buttocks. In comparison of both photos wound assessment

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dated 4/1/2020 shows that R3's wound area was multiple times larger than the wound assessment done on 3/26/2020.

On 12/2/2020 at 11:44 AM. After showing both wound assessments dated 3/26/2020 and 4/1/2020 for comparison. V17 (Regional Consultant) stated, "This is not right, I think these assessments are not right. R3 had pressure ulcer on the sacrum and based upon the wound assessment dated 3/26/2020 and 4/1/2020 the pressure ulcer deteriorated. As I remember, it was classified as a blister but the area became larger from 3/26/2020 to 4/1/2020. It should at least be included in the care plan to address this wound regarding preventing it to worsen. R3 was not seen by a Wound Doctor, and V10 (Nurse Practitioner) was in charge of her medical care including wounds."

On 12/2/2020 at 12:20 PM., V10 (Nurse Practitioner) stated that "R3 had pressure sore on the sacrum and was not eating well. R3's wound became worse because R3 was declining. On the medical point, there needs to be interventions like reposition Q2H, keeping clean and dry, proper treatment, low air loss mattress in order to prevent pressure sore from worsening. Regarding care plan, I am not in-charge of doing the care plan. But there should be interventions to prevent further deterioration of the pressure ulcer either in the care plan or as an order. I understand that even if a resident has co-morbidities it is still necessary to provide interventions to prevent pressure ulcer from progressing. R3 was not in hospice, but I advised her to be in hospice. It was my understanding that R3 will be admitted to hospice after discharge to home."

On 12/3/2020 at 10:05 AM., V35 (Registered

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Dietitian) stated, "I am familiar with R3 and that is my assessment on 3/20/2020 as shown in my notes. That is my only assessment, if I did not do another assessment, the nursing staff did not inform me about R3's sacral pressure ulcer."

When R3's wound assessments dated 3/26/2020 and 4/1/2020 that includes photo of R3's sacral pressure ulcer was presented to V35.

V35 stated, "For me it is only a blister, and I do not need to address R3's nutritional needs related to her wound because it is only a blister. Because it was identified as a blister it is a blister, it doesn't matter how it looks like, for me it is a blister."

When R3's Full Care Plan was presented to V35 and was asked about the lack of nutrition intervention for R3's sacral pressure ulcer in the Care Plan.

V35 stated, "Because it was only a blister then I do not need to do a nutritional care plan for the wound."

When R3's Order was presented to V35 and was asked about the lack of nutritional supplement to help pressure ulcer healing.

V35 stated, "Protein supplement will be helpful for resident with pressure ulcer for healing of tissue. But since it was only a blister it was not recommended and was not included in R3's order. Yes, R3 has poor appetite."

R3's Full Care Plan was reviewed and nutrition for sacral pressure ulcer was not addressed and not even mentioned.

R3's Orders does not include nutritional

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supplement to facilitate or help with pressure ulcer.

R3 has 2 Skin Evaluations dated 3/19/2020 and 3/26/2020.

In the initial skin evaluation dated 3/19/2020, R3's sacral area skin was intact. On the next skin evaluation that was done on 3/26/2020 when sacral pressure ulcer was first discovered. The notes written by V9 (Wound Coordinator / Licensed Practical Nurse) reads: Writer notified by staff nurse that R3 has a new alteration to the sacrum. Wound care team assessed resident and observed open blister, treatment in place. V10 (Nurse Practitioner) was notified, according to resident incontinent and Braden Score 16 (The Braden scale assesses a patient's risk of developing a pressure ulcer) R3 remain at risk for further skin alteration. However, skin preventive measures remain in progress.

After further review of R3's electronic health record, skin preventive measures does not reflect on R3's notes, was never care planned or placed as an order from 3/26/2020 when sacral pressure ulcer was discovered up to 4/2/2020 when R3 was discharged from facility to home.

And based on the wound assessments photos on both 3/26/2020 and 4/1/2020. After only 5 days, R3's sacral pressure ulcers has increased in size multiple times. Although the facility on both assessments categorized R3's pressure ulcer as blister, wound assessment on 4/1/2020 sacral area not only covers the sacrum but also the large area of the buttocks.

Facility Policy on Skin Care Treatment with review

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S9999	Continued From page 8 date 8/5/2020 provided multiple procedures to prevent worsening of pressure ulcer that the facility failed to provide. It reads: It is the policy of this facility to ensure prompt identification, documentation and obtain appropriate topical treatment for residents with skin breakdown. Charge nurse must document in the nurse's notes and / or the wound report form any skin breakdown upon assessment and identification. Resident who are not able to turn and reposition themselves will be turned and reposition every 2 hours unless specified in the POS. Resident with Stage 3 and / or 4 pressure ulcer will be placed in specialized air mattresses like low air loss mattress with an incontinent brief if they are incontinent only, incontinence pad which will also act as repositioning aid, and either a flat sheet or a fitted sheet which are all necessary to prevent infection control issue. (B)	S9999		