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	IL6013023	A. BUILDING: _____ B. WING _____	06/25/2021

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S 000	Initial Comments Annual Licensure	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210d)2) 300.1210d)5) 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 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: 2) All treatments and procedures shall be administered as ordered by the physician.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. These requirements are not meet as evidenced by: Based on observation, interview, and record review, the facility failed to obtain a new Physician ordered treatment with the deterioration of a pressure ulcer, identify the appropriate staging of a pressure ulcer, implement a Physician ordered treatment, implement new interventions following the development of a pressure ulcer, and complete weekly pressure ulcer assessments for three of four residents (R3, R5, R41) reviewed for pressure ulcers in the sample of 34. This failure resulted in R5's pressure ulcer deteriorating from a Stage 3 to unstageable. Findings include: According to NPIAP (National Pressure Injury Advisory Panel) Pressure Injury Stages, "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 3 Pressure Injury: Full-thickness skin loss	S9999		

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S9999	Continued From page 2 Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed." The facility's Quality of Life/Quality of Care policy, dated 8/2017, documents, "Skin Integrity Processes: A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing." The facility's Weekly Pressure Ulcer Progress Report policy, dated 6/2020, documents, "Any signs/symptoms of infection or poor response to treatment will be reported to the DON (Director of Nursing) and to the Physician for review for new orders." The policy also documents, "Care plan nurse will be responsible to add skin issues to Care Plan with each incident to identify interventions to promote healing. MDS (Minimum Data Set) Assessment Coordinator will be	S9999		

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S9999	Continued From page 3	S9999		

responsible to follow up and monitor the Care Plan and add updates as needed. Updated information regarding residents skin condition and Care Plan will be reported to the CNAs (Certified Nursing Assistants for education to provide quality care to heal and attempt to prevent further issues." The policy also documents, "to provide weekly assessment and documentation of all pressure/stasis ulcers. To help prevent infections and other complications of pressure/stasis ulcers. Upon assessment of pressure/stasis ulcer, document on the weekly pressure ulcer progress report. Document in the Nurses Notes. The area will then be monitored on a weekly basis on the weekly pressure ulcer progress report."

On 06/22/21 at 11:00 AM, R5 had a hydrocolloid dressing in place on R5's coccyx.

R5's Braden Scale for Predicting Pressure Sore Risk Assessment, dated 3/25/21, documents a score of 15 putting R5 at risk for developing pressure ulcers.

R5's Skin/Wound note, dated 1/11/2021, documents, "Full thickness open area noted at coccyx measures 0.8 cm (centimeters) round with depth of 0.7 cm."

R5's Pressure Ulcer Care Plan, dated 3/16/21, documents that R5 has a Stage 3 Pressure Area on her coccyx. R5's Care Plan has no documentation of revision to the care plan to include new interventions to prevent R5's pressure ulcer from worsening and/or prevention of new ulcers. On 06/24/21 at 09:23 AM, V5 (Care Plan Coordinator) confirmed that no new interventions had been implemented on R5's care plan to prevent further breakdown or worsening.

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S9999	Continued From page 4 R5's Skin & Wound Evaluation, dated 1/25/21, documents that R5 has a new Stage three (Full thickness skin loss) facility acquired pressure ulcer on R5's coccyx that was identified on 1/11/21. R5's pressure ulcer measured 0.9 cm (centimeters) x 0.5 cm x 0.4 cm with 0.4 cm of undermining as well." R5's Skin & Wound Evaluation, dated 2/5/21, documents, "Wound Measurements: 0.5 cm x 0.2 cm x 0.3 cm. Stalled healing. Wound bed has persistent adherent yellow slough present." R5's Skin & Wound Evaluation, dated 2/11/21, documents, "Wound measurements: 0.5 cm x 0.3 cm x 0.3 cm. Dressing appearance: Missing. Stalled. Dressing was missing at time of assessment. Wound has significant adherent light-colored slough present today." R5's Skin & Wound Evaluation, dated 2/17/21, documents, "Wound Measurements: 0.4 cm x 0.4 cm x 0.1 cm. Dressing appearance: Missing. Stable. Dressing missing at time of assessment. Wound is stable/ unchanged with adherent light-colored slough present. New order includes hydrogel gauze to wound bed." R5's Skin & Wound Evaluation, dated 3/2/21, documents, "Wound measurements: 0.6 cm x 0.4 cm x 0.3 cm. Dressing appearance: Missing. Assigned nurse notified this RN dressing was noted to be missing. Task was added recently to Plan of care for CNA (Certified Nursing Assistant) staff to notify nurse of dressing status and/or if absent." R5's Skin & Wound Evaluation, dated 3/11/21, documents, "Wound measurements: 0.6 cm x 0.5	S9999		

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S9999	Continued From page 5 cm x 0.3 cm." R5's Skin & Wound Evaluation, dated 3/19/21, documents, "Wound Measurements: 0.6 cm x 0.6 cm x 0.3 cm." R5's Skin & Wound Evaluation, dated 3/23/21, documents, "Wound Measurements: 0.6 cm x 0.5 cm x 0.2 cm. Dressing appearance: Missing. The wound bed has transparent pale yellow to light brown slough appearance." R5's Skin & Wound Evaluation, dated 3/29/21, documents, "Wound Measurements: 0.6 cm x 0.5 cm x 0.2 cm. Wound Bed: 80% of wound filled with slough." R5's Skin & Wound Evaluation, dated 4/7/21, documents, "Wound Measurements: 0.8 cm x 0.4 cm x 0.2 cm. Dressing appearance: Missing. The wound has stalled. The wound bed has loose yellow slough." R5's Skin & Wound Evaluation, dated 4/14/21, documents, "Wound Measurements: 1 cm x 0.3 cm x 0.4 cm. Wound Bed: 50% of wound filled with slough. Dressing appearance: Missing." R5's Skin & Wound Evaluation, dated 4/22/21, documents, "Wound Measurements: 0.7 cm x 0.6 cm x 0.4 cm. Wound Bed: 40% of wound filled with slough. Stable. Moderate amount of loose yellow slough easily removed with cleansing leaving less than 50% wound bed covered in adherent yellow slough." R5's Skin & Wound Evaluation, dated 4/30/21, documents, "Wound Measurements: 1.3 cm x 0.6 cm x 0.8 cm. Wound Bed: 70% of wound filled with slough. Deteriorating. Coccyx wound has	S9999		

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S9999	Continued From page 6 increased depth." R5's Skin & Wound Evaluation, dated 5/6/21, documents, "Wound Measurements: 0.8 cm x 0.7 cm x 0.8 cm. Wound Bed: 80% of wound filled with slough. Stable: Essentially unchanged wound. There is little exposed wound bed and portions of the pink wound bed are visible through shallow adherent yellow slough." R5's Skin & Wound Evaluation, dated 5/13/21, documents, "Wound Measurements: 1 cm x 0.6 cm x 1 cm. Wound Bed: 100% of wound filled with slough. Dressing Appearance: Missing. Dressing was reported to be missing by assigned nurse. The wound is essentially unchanged." R5's Skin & Wound Evaluation, dated 5/19/21, documents, "Wound Measurements: 0.7 cm x 0.7 cm x 1 cm. Dressing Appearance: Missing. Stable: Assigned nurse reports dressing was missing." R5's Skin & Wound Evaluation, dated 5/28/21, documents, "Wound Measurements: 0.7 cm x 0.7 cm x 1 cm. Stable. Essentially unchanged in overall involved area from previous assessment." R5's Skin & Wound Evaluation, dated 6/3/21, documents, "Wound Measurements: 1.1 cm x 0.7 cm x 1 cm. Wound Bed: 80% of wound filled with slough." R5's Skin & Wound Evaluation, dated 6/8/21, documents, "Wound Measurements: 1.1 cm x 0.7 cm x 1 cm. Wound Bed: 90% of wound filled with slough. Deteriorating." R5's Skin & Wound Evaluation, dated 6/15/21, documents, "Wound Measurements: 1 cm x 0.8	S9999		

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S9999	Continued From page 7 cm x 1.1 cm. Wound Bed: 100% of wound filled with slough. Dressing Appearance: Missing." R5's Physician's order recap, dated 6/24/21, document the following order: Wound care to coccyx pressure ulcer: Cleanse with soap and water, normal saline or wound cleanser. Apply skin-prep around wound. Fill wound with small piece of Hydrogel gauze and cover with a 4 x 4 Hydrocolloid dressing. Change every three days and as needed if loose or soiled until resolved. The order recap also documents that this order has been in place since 2/17/21. 06/24/21 at 12:03 PM, V13 (Nurse Practitioner) stated, "If the wound got larger, deeper, developed a foul smell, drainage, or symptoms of infection these are signs of a wound worsening. If a wound is stalled or deteriorating the treatment should be changed because that treatment isn't working as evidenced." On 06/24/21 at 02:24 PM, V14 (Wound Nurse), stated "(R5's) wound was full thickness because I could see the structure around it. I staged it at a 3. When a wound covered with slough and you can't tell the depth, it is unstageable. If there is slough in the wound bed, you don't know what's underneath of it. (R5's) wound I could tell based on the depth and the coverage of slough that (R5's) wound deteriorated. I debated changing the order, but I didn't change it at any point. I was mortified initially when I saw it uncovered because she is incontinent of bowel, but has an indwelling urinary catheter. Being uncovered the wound could become contaminated. There were times when I would go in that the dressing would not be in place. I educated the CNAs and nurses about it."	S9999		

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S9999	Continued From page 8 Skin and Wound Assessment dated 6/3/21 at 9:04pm indicates R41 was admitted on 6/2/21 with a Stage 2: Partial thickness skin loss with exposed dermis coccyx pressure ulcer measuring 0.1cm (centimeter) x 0.3cm x 0.4cm, depth 0.1cm; no drainage. R41's Skin and Wound Assessment dated 6/9/21 at 10:12pm documents that R41 continues with a Stage 2 coccyx pressure ulcer with measurements 0.3cm x 0.4cm x 0.9cm, depth 0.1cm; wound bed 40% filled with slough and light drainage. R41's Skin and Wound Assessment dated 6/16/21 at 5:07pm documents R41 with Stage 2 coccyx pressure ulcer measuring 0.2cm x 0.5cm x 0.5cm, depth 0.1cm; wound bed 80% filled with slough, no drainage. On 6/24/21 at 12:04pm, R41was noted to have an irregular shaped pressure wound in the crease/crack of his coccyx. The wound was noted to be full thickness with slough (whitish/yellow coating) in the base of the two distinct adjoining crater areas of the wound. The actual depth of the wound could not be visualized due to the slough covering the wound base. R41's Skin wound assessment dated 6/23/21 documented R41's coccyx wound was a Stage 2 pressure area that was acquired on admission. No measurements were initially documented in the assessment. R41's Skin and Wound Assessment dated 6/23/21 at 9:30 pm documents R41 with Unstageable: Obscured full thickness skin and tissue loss due to slough and/or eschar. Coccyx wound measurements 0.5cm x 0.8cm x 0.9cm,	S9999		

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S9999	Continued From page 9 depth not applicable; remainder of assessment is incomplete/not documented. R41's Pressure Ulcer Care Plan created on 6/9/21 did not contain interventions to reduce pressure. On 6/24/21 at 3:00pm V5, Care Plan Coordinator stated that she was told not to put the same interventions in more than one area, so she created a skin impairment Care Plan that was not specific to pressure ulcers. On 6/24/21 at 3:00pm V14, Wound Nurse stated that he initially marked R41's coccyx wound on 6/23/21 as Stage 2 even though he had observed the wound had worsened because he was not aware that a wound could "stage up" from the initial admission stage. V14 stated he was not "wound certified" and agreed the wound should be unstageable due to the wound now full thickness and base being covered with slough. V14 stated that R41 "Will not stay off his back." No interventions were found to address R41's position preferences. R3's Physician Order Sheet shows an order for "2% Miconazole Nitrate cream topically to open gluteal skin area x 3 with cares and (as needed) until resolved." On 5/13/21, R3's Nurse's Notes document the following: "Noted a small 0.2 x 0.3 cm (centimeter) scab on (R3)'s pelvic area. Also had a pink colored pimple on his leg near the knee." On 5/14/21 R3's Nurse's Notes document the following: "Area to the (right) inner buttocks measures 3 cm x 2 cm in size, edges are detached and red, center is scabbed over,	S9999		

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S9999	Continued From page 10 surrounding skin is intact, (R3) denies discomfort when area touched, but (complains of) pain if the (medicated) cream is applied for wound healing and protection." On 6/23/21 at 9:30 A.M. V2 (Director of Nursing) confirmed that R3 "did have open areas (to the buttocks)" and that there was no further documentation in the medical record concerning R3's pressure ulcers and open areas. (B)	S9999		