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	IL6000012	A. BUILDING: _____ B. WING _____	C 02/18/2021

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S 000	Initial Comments Complaint Investigation: 2161074/IL131059	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210d)2)3)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 300.1010 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 of five percent or more within a period of 30 days.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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. 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. 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,	S9999		

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S9999	Continued From page 2 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 observation, interview, record review, the facility failed to accurately assess, measure, and obtain a treatment order for a newly acquired pressure ulcer, complete pressure ulcer treatments as ordered, and reposition a dependent resident at least every two hours for two of three residents (R2, R3) reviewed for pressure ulcers on the sample list of three. These failures resulted in R2's two stage II pressure ulcers to the buttocks deteriorating to unstageable, and R2 developing a new unstageable pressure ulcer to the right foot. Findings Include: The facility Pressure Injury and Skin Condition Assessment Policy 1/17/18 documents: "a wound assessment will be initiated and documented in the resident chart when a pressure and/or other ulcers are identified by a licensed nurse.", Changes to the skin will be promptly reported to the charge nurse who will perform the detailed assessment. "At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.", "A wound assessment for each identified open area will be completed and will include: site location, size, stage of pressure ulcer, odor, drainage, description, date and initials of the individual performing the assessment.", "When there are weekly changes which require physician and responsible party notification,	S9999		

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documentation of findings will be made in the clinical record. These changes include, but are not limited to: new onset of purulent drainage, new onset of odor, cellulitis, increased pain related to wound, significant increase in wound measurements, onset of new wound.", "Physician ordered treatments shall be initiated by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses notes."

1.) R2's MDS (Minimum Data Set) dated 11/26/20 documents R2 requires extensive assistance with bed mobility and only transferred once or twice with one assist.

R2's Skin Assessment dated 1/20/21 documents, R2 has an unstageable Pressure Ulcer (PU) to the left ankle measuring 0.2 cm (centimeters) by 0.3 cm, a stage II PU to the right buttock measuring 1.4 cm by 0.6 cm, and a stage II PU to the left buttock measuring 1.9 cm by 0.6 cm. This assessment also documents all wounds are healing and have granulation tissue.

There is no documentation in R2's January 2021 TAR (Treatment Administration Record) or Progress Notes that R2's PU treatments were completed on 1/23/21 and 1/24/21.

R2's Skin Assessment dated 1/27/21 documents, R2 has an unstageable PU to the left ankle measuring 0.5 cm by 0.5 cm that is worsening and now covered in slough and granulation tissue. This Assessment also documents, a stage II PU measuring 2.5 cm by 0.5 cm, that is worsening and covered in slough, but does not document where this PU is located.

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S9999	Continued From page 4 R2's ongoing Weekly Wound Measurements dated 1/27/21 documents R2 has a stage II PU to the right buttock measuring 2.5 cm by 0.5 cm, and a stage II PU to the left buttock measuring 1.0 cm by 0.7 cm. {An increase in size of all wounds from the week prior.} R2's Skin Assessments dated 2/3/21 and 2/10/21 both continue to document R2's bilateral buttocks ulcers as stage II and R2's left ankle ulcer as an unstageable. R2's Physician Order Sheets dated February 2021 documents the following orders: 1. Wound care for right and left buttocks wounds - clean with wound cleanser, apply Santyl {an enzyme used to loosen slough}, cover wound bed ONLY with calcium alginate, and cover with 8 in (inch) by 8 in bordered foam dressing daily and PRN {as needed}. 2. Wound care for left ankle wound - clean with wound cleanser, apply Santyl, covered with 2 in by 2 in bordered foam dressing daily and PRN. On 2/17/21 at 2:15 pm, V3 ADON (Assistant Director of Nursing)/Wound Treatment Nurse entered R2's room to complete the ordered dressing changes to R2's left ankle and bilateral buttocks. V3 removed a large foam dressing, with a moderate amount of serosanguineous {clear yellow} drainage dated 2/16/21 from R2's coccyx area, to reveal one wound to left and one wound to right buttocks, both covered in yellow slough. V3 measured R2's left buttock wound as 2 cm by 2.1 cm {more than doubled in size since 1/27/21}, and right buttock wound as 2.2 cm by 1.2 cm. V3 confirmed that R2's dressing that was removed did not have the ordered calcium alginate on the wounds, and stated the wounds are looking	S9999		

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worse and are covered in slough. V3 then removed a dressing to the left ankle to reveal a wound measuring 1 cm by 0.6 cm, with a beefy red wound base. R2 had a foam dressing to right lateral foot dated 2/15/21. At this time, V3 stated, R2 doesn't have a wound or ordered treatment to the right foot, "maybe it's there for prevention only." V3 removed the dressing to R2's right foot, which had a scant amount of Sanguineous {bloody} drainage, to reveal a wound that V3 measured and described as a "0.5 cm by 0.4 cm by 0.1 cm, full thickness, stage 3 pressure ulcer." V3 cleansed the wound with wound cleanser and applied a dry foam dressing to the wound and stated, "I will have to call the doctor and get a treatment." V3 stated, "when the nurse finds a wound, they are to notify the physician, POA (Power of Attorney) and RD (Registered Dietician) for orders after completing a full assessment of the wound, including measurements." V3 also stated that once a treatment is completed, it is signed out on the TAR.

On 2/18/21 at 9:26 am, V13 LPN (Licensed Practical Nurse) stated, on 2/15/21, V13 noticed "a scab, so an unstageable pressure area, on the outside of (R2's) right foot that measured 0.2 cm by 0.3 cm." V13 stated V13 observed the new wound when doing R2's other dressing changes, and that V13 measured the new pressure wound, and put the dry protective dressing on the wound but isn't sure if V13 charted the new wound. V13 stated, V13 "forgot to fax the doctor to get a dressing {order} for it, but you can only do so much."

On 2/18/21 at 10:13 am, V3 ADON/Wound Treatment Nurse stated with R2's buttocks wounds being covered with slough and not being able to see the wound bed, the wounds (right and

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left buttocks) are actually unstageable PU instead of stage II PU. At this time, V3 confirmed that they have been slough covered since the end of January, therefore the wound assessments dated 1/27/21, 2/3/21, and 2/10/21 are not accurate.

R2's Progress Notes document R2 was seen by V12 RD on 2/8/21 and 2/15/21. V12's Progress Note on 2/8/21 document R2 has stage II PU that are deteriorating so V12 recommends adding zinc for wound healing. The Progress Notes on 2/15/21 documents R2 has triggered for a weight loss and with having compromised skin, weight loss is contraindicated so V12 recommends a nutritional drink twice a day.

On 2/18/21 at 8:50 am, R2 was sitting up in a low to the floor rolling chair with R2's socked feet resting on the foot pedals. At 9:05 am, R2 was still in the chair but R2's right foot was resting on the floor. R2 remained in the same position at 9:24 am. At 9:52 am, R2 was in the same position but had heel protectors on bilateral feet. From 9:52 am - 11:35 am based on 15 minute checks, R2 remained in the same position. At 11:35 am, V14 CNA (Certified Nursing Assistant) stated R2 got up from bed into the low sitting rolling chair at 6:45 am. V14 stated R2 was lifted up with a mechanical lift and changed at 9:45 am {3 hours after being gotten up}, then placed back into the chair, and that is the only care provided to R2 since R2 has been up but R2 will be put back into bed after lunch. At 11:47 am, R2 remained sitting up in the chair, in the same position and V14 stated, "we get to the residents when we can. It might not be every two hours or less but it's not like they go 7-8 hours without care. Maybe 2.5-3 hours." R2 remained in the same position at 12:00 pm, 12:12 pm, 12:25 pm, and then was placed in bed at 12:30 pm {2 hours and 45

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minutes after last repositioned}.

On 2/18/21 at 11:00 am, V12, RD stated V12 knew that R2's wounds were deteriorating based off of R2's skin assessments, but didn't realize R2's wounds were unstageable, and had been since January because the skin assessments documented the wounds to be stage II PU. V12 stated had V12 known that R2's buttocks wounds had deteriorated to unstageable's, back in January, or that R2 had developed a new Stage III PU, in addition to the zinc and nutritional drink that V12 recommended, V12 would have also ordered extra protein and calories to boost the wound healing.

On 2/18/21 at 11:21 am, V11 Physician stated the facility notified V11 on 2/17/21 that R2's wounds are worsening and that R2 has a new stage III PU to the right foot. V11 stated, treatments should be done as ordered. V11 stated, the problem is R2 "is getting weaker and weaker and can't move much on her own, and (R2's) nutrition isn't very good. (R2) needs to be repositioned at least every two hours and have the areas off loaded as much as possible." V11 also stated R2 is being seen by an RD and the recommendations are put into place to assist with wound healing.

2.) R1's Medical Record documents R1 was admitted to the facility on 1/29/21.

R1's Physician Orders dated January 2021 documents treatment orders for wound care for wounds on R1's back, left heel and bilateral buttocks.

R1's 72 Hour Admission Charting dated 1/29/21 documents R1 has two superficial areas to the

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S9999	Continued From page 8 left buttock, one area to the right buttock that is 2 cm (centimeter) and hard, and to the coccyx. R1's Progress Notes dated 1/29/21 by V4 LPN (Licensed Practical Nurse) documents, R1 has a superficial wound to left buttock and one to coccyx area and one to right buttock that has a 2 cm round hard area all wounds have no noted drainage and all area were cleaned and new dressings applied. There is no assessment of the wounds according to the facility policy and no measurements of these wounds. On 2/17/21 at 2:15 pm, V3 ADON (Assistant Director of Nursing)/Wound Treatment Nurse stated when a resident is admitted with a pressure ulcer, or develops one in the facility, the nurse is to do a complete wound assessment and document the measurements of the wound. On 2/18/21 at 12:31 pm, V4 LPN stated V4 was the nurse on duty when R1 was admitted to the facility. V4 stated upon R1's admission, R1 had three pressure areas, all in buttocks area. One was hard about 2 cm on the right buttock, then on the other side, R1 had two superficial areas that were blanchable, did not measure them. (B)	S9999		