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	IL6001739	A. BUILDING: _____ B. WING _____	C 02/05/2021

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S 000	Initial Comments Complaint 2120605/IL130542 F 686 G cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)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 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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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.

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.

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S9999	Continued From page 2 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 interview and record review, the facility failed to follow their policy for the prevention of pressure ulcers including daily skin checks, ensuring proper placement of a medical brace, and wound assessment upon initial observation for one resident (R1) reviewed for pressure ulcers. These failures resulted in R1 developing multiple Deep Tissue Injuries and an unstageable pressure ulcer subsequently requiring hospitalization for wound infections. Findings include: The facility's undated Pressure Ulcer Prevention policy documents the following: "A pressure ulcer is defined as any lesion caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed." "An integral part of any skin care program is a systematic skin evaluation. It is through these inspections that early skin problems can be detected and interventions started." "These inspections start on admission. Evaluations must continue on a daily basis for all residents that are at risk for skin breakdown." "Pressure ulcers may develop from positioning as well as the use of medical devices. Pressure ulcers may develop from the use of nasal tubing, catheters, casts,	S9999		

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braces, cervical collars or other medical devices. Monitor all devices for proper placement to avoid pressure on surrounding tissue."

The facility's Wound Assessment policy revised 7-1-19 documents, "New wounds and/or other skin impairments/abnormalities will be assessed and documented using the Skin and Wound Program in the electronic medical record upon being observed."

R1's nursing notes dated 1-29-21 document R1 was sent to a local hospital for "sepsis wounds right leg peripheral artery disease."

R1's admission nursing assessment dated 1-15-21 documents R1 had no skin issues on admission but was at risk for skin injury. R1's Braden pressure ulcer risk assessment dated 1-15-21 documents R1 is at risk for pressure ulcers.

R1's emergency room orders dated 1-15-21 document R1 needed emergency admission to a skilled nursing facility with orders for therapy and to wear his immobilizing right leg brace at all times. There were no other orders related to R1's right broken leg and leg brace.

R1's Skin and Wound Evaluation form dated 1-22-21 note the following areas were found that day: Coccyx a DTI (Deep Tissue Injury) measuring 4.7cm (centimeters) x 2.7cm, a right shin Medical Device Related Pressure Injury, DTI measuring 5.3cm x 2.7cm, right lateral malleolus (ankle) Medical Device Related Pressure Injury, DTI measuring 7.5cm x 4.3cm, a right thigh Medical Device Related Pressure Injury, DTI measuring 5.2cm x 2.4cm, a right heel DTI measuring 2.1 x 1.2 DTI and a MASD (Moisture

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S9999	Continued From page 4 Associated Skin Damage) to the sacrum measuring 10.5cm x 8.3cm. R1's Skin and Wound Evaluation forms dated 1-24-21 document the following areas were found that day: Right trochanter Stage 1 measuring 5.5cm x 3.9cm, left trochanter Stage 1 measuring 3.9cm x 2.9cm, and left ischial tuberosity unstageable pressure ulcer measuring 7.2cm x 4.1cm. R1's POS (Physician Order Sheet) documents R1 was admitted on 1-15-21 with diagnoses of paraplegia and a fracture of the lower end of his right femur. There are no orders for the care and treatment of R1's right leg/immobilizing brace until 1-22-21, after R1 developed pressure ulcers to that area. An order obtained 1-22-21 states "remove brace to right lower leg extremity and complete skin check every shift." R1's care plan initiated 1-16-21 documents R1 is at risk for pressure ulcers and to monitor for any changes in skin appearances. R1's care plan does not contain any mention of R1's right leg brace. R1's current care plan does not include intervention related to monitoring R1's leg/brace for tightness, circulation, or reddened areas or when and for how long to remove the brace. R1's admission MDS (Minimum Data Set) dated 1-22-21 documents R1 was alert and orientated, needed extensive assistance of two for bed mobility and transfers and had no pressure ulcers upon admission, but was at risk for developing pressure ulcers. R1's MAR/TAR (Medication Administration Record, Treatment Administration Record) contains no documentation of daily skin	S9999		

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assessments or monitoring of R1's right leg brace from admission on 1-15-21 until 1-22-21.

R1's nursing notes dated 1-17-21 is the first time R1's leg brace is mentioned since admission on 1-15-21. This note states, "(R1) able to place leg brace on himself, no swelling or pain noted pedal and radial pulses in intact." R1's nursing notes from 1-15-21 to 1-22-21 do not contain consistent assessment/monitoring of R1's right leg with R1's brace other than R1's 1-15-21 Nursing note nor do they contain general daily skin monitoring. These notes do not contain any documentation of R1's brace being removed and a skin assessment completed.

R1's OT/Occupational Therapy evaluation dated 1-17-21 documents R1 had a recent fall with a right distal femur fracture with right lower extremity brace in extension, right shoulder pain with plans to improve strength, range of motion and activity tolerance. R1's OT note dated 1-18-21 documents R1's knee immobilizer was causing pain and redness. Immobilizer adjusted and washcloths placed to help reduce risk of skin breakdown. There is no mention of R1's immobilizer being adjusted/washcloths placed after this note until 1-24-21 nor is there any documentation that the redness was monitored. R1's OT note on 1-20-21 documents R1 complained of spasm in left leg. This note documents, "Leg inspected to check skin integrity. Pressure sore developing on left hip. Nursing notified." There is no further documentation and treatment of R1's left leg area in R1's medical record until documented on the Skin and Wound evaluation form on 1-24-21.

On 2-3-21 at 12:20 pm, V9 COTA/Certified Occupational Therapy Assistant, stated on

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1-20-21, V9 noted a nickel sized reddened area with a tan center on R1's left hip area. V9 stated she reported the area to nursing but could not remember what nurse. V9 stated at times she would check R1's brace for tightness by putting her fingers under the brace but did not take off the brace and inspect R1's skin. V9 assisted R1 with bathing, wrapping the brace so it would not get wet but not taking the brace off.

R1's PT/Physical Therapy evaluation, dated 1-16-21 documents R1 had a recent fall with a right distal femur fracture with right lower extremity brace in extension, right shoulder pain present to therapy with deficits in transfers and bed mobility. R1's PTA/Physical Therapy Assistant note dated 1-21-21 at 11:38 am documents "This writer and nursing put another mattress on bed for pressure relief with nursing and (R1) reporting (R1) has pressure areas on gluteal area." There is no other documentation of an assessment or treatment of this area until 1-22-21 at 11:30 am when the Skin and Wound Evaluation form was filled out and orders for treatment were obtained.

On 2-3-21 at 10:30 am, V6 PTA stated she would at times check R1's brace for tightness and adjust it but did not remove it and inspect his skin. V6 stated that on 1-18-21, she did notice some pink area on R1's right upper leg where the brace ended so she readjusted it and told nursing about the reddened area. The next day, V6 and V9 noted a reddened area to R1's left hip which V9 reported to nursing. V6 does not remember any other pressure/red areas.

On 2-3-21 at 11:30 am, V7 Licensed Practical Nurse stated that he occasionally worked with R1. V7 stated that he does not remember having

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orders to check R1's brace. V7 stated on shower days, he might adjust it and cover it for the shower but does not remember taking it off and evaluating R7's leg under the brace.

On 2-3-21 at 11:10 am, V5, Registered Nurse Unit Manager, stated that she spoke with R1 on 1-18-21. V5 stated that R1 had a routine at home and liked to do things a certain way. V5 stated that R1 needed staff assistance for bed mobility and transfers. V5 stated R1 did not always want to be repositioned. V5 stated R1 had his brace on at all times but could remove it for bathing and skin checks. V5 expected staff to check for the positioning of the brace, check for fit/tightness and assess the skin beneath the brace at a minimum of daily. There is no documentation of these brace checks being completed. V5 stated that on 1-22-21, when pressure ulcers were found, R1's brace was on too tight. V5 stated that sheepskin and monitoring of brace three times a day was implemented on 1-22-21.

On 2-3-21 at 12:10 pm, V8 CNA/Certified Nursing Assistant stated that when R1 was admitted, R1 stated he could turn and reposition himself but they found out that he could not. V8 stated that she did observe some red areas on R1's right leg but could not remember when. V8 stated that when R1 was first admitted, she does not remember any sheepskin/padding being placed between R1 and his leg brace.

On 2-3-21 at 1:30 pm, V2 Director of Nursing, verified there were no orders or care plan interventions upon admission for R1's leg immobilizing brace. V2 stated she was not aware of some of the reddened areas found on R1. V2 stated they should have been reported, assessed and a obtained a treatment order when the areas

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S9999	Continued From page 8 were first observed. V2 stated there were skin assessments checked off as being completed on R1's TAR on 1-15, 1-19 and 1-22-21 but could not tell if R1's brace was removed for those checks. V2 stated skin checks were not documented as being completed daily as per their policy. V2 stated they are now implementing a new skin check sheet that shows more detail. (B)	S9999		