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
	IL6016752	A. BUILDING: ______ B. WING ______	06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN VILLAGE HLTH & WELL	12525 W RENAISSANCE CIRCLE HOMER GLEN, IL 60491

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Annual Licensure and Certification Survey STATEMENT OF LICENSURE FINDINGS: 300.610a) 300.1210b) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1	S9999		

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:

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:

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 regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess for pressure relief for a resident who was wearing an orthotic boot that enclosed their foot. This failure resulted in the resident sustaining an unstageable pressure ulcer in their left heel.

This applies to 1 of 3 residents (R42) reviewed for pressure ulcers in the sample of 12.

The findings include:

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S9999	Continued From page 2 The Face Sheet indicates that R42 is 72 years-old, she has multiple medical diagnoses which include fracture of unspecified part of neck of the left femur, dislocation of internal left hip prosthesis, foot drop (left foot). Admission note showed that R42 was admitted to the facility on 6/5/21 wearing an orthotic boot on the left foot. MDS (minimum data set) dated 6/12/21 indicated that R42 is alert and oriented and requires extensive assistance for bed mobility, locomotion, dressing, toileting, and personal hygiene. R42's Braden Scale Risk Assessment (Skin Assessment) dated 6/5/21, shows that R42 is very high risk for skin breakdown. On 6/21/21 at 3:00 PM, R42 was resting in bed, she was awake, alert, and oriented. R42 has a wound dressing to her left foot. R42 stated, she had multiple surgeries on her left lower extremities in the past month related to a fall incident at home resulting into a fracture. She was admitted to the facility a few weeks ago (6/5/21), with an orthotic boot on her left foot. R42 said that the boot was placed on her from the hospital. Since then, the boot has been on her, without anyone visually assessing her left foot that was enclosed in the orthotic device. R42 has been complaining on and off of pain/burning sensation to her left foot. The pain was more intense at nighttime. R42 would tell staff about the pain and they would loosen up the boot which gave her a feeling of relief. However, no one had ever removed the boot to assess her foot. One day (6/16/21), one of the staff was assisting her with hygiene care (R42 was unable to re-call who it was) and suggested to clean her feet. The staff removed her boot and found the pressure ulcer.	S9999		

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S9999	Continued From page 3 On 6/22/21 at 8:52 AM, V3 (Wound Care Nurse) stated that R42 had a surgery on her left hip, she was wearing a PRAFO (Pressure Relief Ankle Foot Orthosis) boot on her left foot upon admission to the facility. It was reported that R42 was complaining of pain on her left foot, and upon assessment (on 6/16/21) she had open skin on the left heel which was unstageable due to slough formation in the wound bed. V3 also stated that she was not sure if the staff who admitted R42 did a full body assessment. However, the facility's policy requires staff to do a full body assessment which includes a head to toe skin assessment upon admission. The PRAFO boot was placed on R42 for her foot drop and not for offloading. This device was lined with sheep skin (fur) for comfort, but with R42's boot, the lining in the heel area had worn off and her left heel was resting directly on the frame of the boot which put pressure on it. On 6/22/21 at 11:39 AM, V3 rendered wound care to R42's unstageable pressure ulcer on the left heel. R42 repeated what she said from the day before that no one had assessed or seen her left foot until 6/16/21. R42's orthotic boot was shown to surveyor. The boot had a soft inner lining, however, the lining of the heel area had flattened and hardened from the secretions of her wound. On 6/22/21 at 10:15 AM, V7 (Nurse), stated that on 6/16/21 V10 (Occupational Therapist/OT) notified V7 about R42's wound. V10 was assisting R42 and took off the boot. V10 found the wound and immediately notified V7. V7 stated "R42 told me that she has been complaining of pain to the nurse. Everyday each shift has a group of residents that they are responsible to do a full body assessment on for Medicare charting. R42 is assigned to night shift staff and I believed that the orthotic boot order indicates to keep it on	S9999		

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S9999	Continued From page 4	S9999		

while in bed. I should have also check but I didn't. She is high risk for pressure ulcer and has history of pressure sore in the left and right buttocks and upper posterior left thigh. Had she (R42) said anything to me I could have assessed it right away and taken care of the problem."

On 6/22/21 at 12:18 PM, V8 (Wound Care Physician) gave the following statement: If a resident has some sort of removable device and the resident started to complain of pain related to it, the staff must remove the device and do an assessment. If the staff is not sure whether to remove the device, they should call the physician. If V8 was notified about this type of concern, V8 would have instructed the staff to remove the boot and do a skin assessment. This situation could have been prevented. If the staff had done it right away, it could have been caught as stage 1 or DTI. Loosening the boot does not relieve the pressure on the foot.

On 6/22/21 at 3:35 PM, V11 (Nurse), stated that when R42 first came in, they (staff) did a full body assessment. V11 took R42's boot off when she complained of burning sensation to her foot. When V11 assessed R42's heel, she (V11) noted that it was a little boggy (extra soft which was unusual). V11 put barrier cream to the left heel for comfort and removed the boot temporarily and placed R42's foot on top of a pillow to relieve the foot. V11 also said she could not recall calling the doctor about it.

On 6/23/21 at 12:12 PM, V2 (Director of Nursing/DON) stated that when a resident is admitted with splints or supporting device the staff must take off the device and completely assess what is underneath. The staff should also remove the device during shower days to assess

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S9999	Continued From page 5	S9999		

the skin, and if the staff is not familiar with the resident, they should remove device and assess the skin.

R42's progress notes was reviewed, and it showed documentation from 6/5/21 through 6/15/21 of R42's left boot in place due to foot drop, able to wiggle toes and was noted to have edema to both lower extremities. A physician note dated 6/9/21 showed that R42 has high risk for developing contractures, pressure ulcers, poor healing or fall if not receiving adequate therapy and pain control. The 6/16/21 progress note showed that a wound was found on the left heel which extended up to the Achilles tendon with the circular portion measuring Length (L) 5.0 centimeter (cm) x Width (W) 5.0 cm x Depth (D) 0.2 cm. The wound bed was covered 40% with slough and partial scabbing in the remaining 60%. The wound appears to be pressure related.

There was no evidence of documentation that R42's left foot was fully assessed, and the boot was ever removed for foot relief prior to the discovery of her pressure ulcer. Facility was unable to present documentation of an actual skin assessment done during shower or bathing time.

Facility's Pressure Injury Reduction Policy and Procedure showed:

Policy: Skin assessments and risk assessments for pressure injury are performed, individualized care plans are formulated to address identified needs, and interventions are implemented, monitored, as needed to reduce the incidence of pressure injuries, and promote healing of existing injuries.

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S9999	Continued From page 6 Procedures: 1. All clients receive a skin assessment to identify the status of the skin and note areas of skin compromise such as pressure injury, wound bruise, skin tear, surgical site, other. The skin assessment is performed beginning on admission/re-admission. Skin integrity is monitored routinely in the course of care, and skin compromises that may be noted are reported to the nurse. (B)	S9999		