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
	IL6006100	A. BUILDING: ______ B. WING ______	C 12/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY PLACE	1415 WEST FOSTER AVENUE CHICAGO, IL 60640

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S 000	Initial Comments COMPLAINT INVESTIGATION: 2189362/IL00141438	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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.

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.

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 met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to follow standard of practice when using a low air loss mattress, follow physician orders for wound care and failed to provide necessary care and services to prevent a sacral wound from reopening and prevent worsening of pressure ulcers for 2 (R1 and R2) out of 3 residents reviewed for pressure ulcers. This failure resulted in R1's sacral ulcer reopening and worsening of the sacral and buttocks ulcers which required hospitalization for debridement.

Findings include:

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S9999	Continued From page 2	S9999		

R1's face sheet reads an admit date of 03/31/2021. Admitting diagnoses read multiple pressure ulcers, morbid obesity and the need for assistance with personal care.

V3's (R1's Primary Physician) progress note dated 04/02/2021 06:04 PM reads R1 was severely deconditioned with worsening strength.

V4's (Wound Physician) progress note dated 04/06/2021 11:54 PM reads R1 admitted to the facility with wounds to both buttocks stage 3.

V14's (Physical Medicine and Rehabilitation Physician) progress note dated 04/19/2021 08:57 PM reads R1 is max assistance for toileting.

V4's progress note dated 07/13/2021 11:50 AM reads R1's buttock pressure ulcers are larger and redder. Left buttocks wound measured 16.2 X 13 X 0.2 cm (centimeter) compared to the previous week's (07/06/2021) measurement of 8 X 4.5 X 0.2 cm. The right buttocks wound measured 10.7 X 7 X 0.2 cm compared to previous week's measurement of 10.2 X 7 X 0.2 cm.

V15's progress note dated 07/15/2021 10:46 AM reads R1 remained max assistance for toileting.

V4's progress note dated 07/20/2021 11:54 AM reads "Long discussion about why [R1's] buttocks wounds are worse. [R1] uses a urinal and sometimes [R1] spills it because [R1] penis is retracted that gets [R1's] dressings wet. Last night [R1] slept soundly and wet [R1] during the night." Left buttock wound now measures 17.5 X 14 X 0.2 cm and right buttock wound measures 16 X 14 X 0.2 cm.

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S9999	Continued From page 3	S9999		

V4's progress noted dated 08/03/2021 09:15 AM reads R1 now has a new sacral ulcer that is deep measured 5.5 X 1 X 3.2 cm. V4's progress noted dated 08/17/2021 09:28 PM reads R1's sacral ulcer is from a previous pilonidal surgery several years ago that took months to heal. Sacral ulcer is deep and slow to heal measured 4.5 X 1 X 3 cm. V4's progress noted dated 08/31/2021 04:11 PM reads sacral ulcer is deeper and goes to the bone measured 4 X 3 X 5.4 cm.

V4's progress note dated 10/12/2021 10:51 PM reads "[R1] buttocks wounds are all larger and more irritated. [R1] uses a urinal but it spills sometimes because of [R1's] obesity." Left buttocks measured 11 X 13 X 0.1 cm, right buttocks measured 15.5 X 9 X 0.1 cm, and sacral pilonidal wound measured 5.2 X 3.6 X 5.4 cm.

V4's progress note dated 10/19/2021 12:01 PM reads "Talked with [R1] because [R1] buttocks wounds are larger and [R1] has abrasions on [R1's] perineum. [R1] reminded me that [R1] uses a urinal and it often spills because of [R1's] obesity and positioning." Left buttocks measured 12.5 X 13.5 X 0.1 cm, right buttocks measured 15 x 16 x 0.1 cm, and sacral pilonidal ulcer measured 5 X 3.6 X 5.6 cm.

V3's progress note dated 10/20/2021 06:26 PM reads R1's "overall prognosis could be very poor with progression of [R1's] sacral wound, that can cause further complication including infection, osteomyelitis (bone infection), and further deconditioning."

V4's progress noted dated 10/26/2021 10:27 PM reads "[R1's] wounds are all larger with necrotic eschar in the perineum, making both buttocks one large wound 32.5 X 21 X 0.2 cm. Sacrum

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S9999	Continued From page 4	S9999		

with stool in the wound 8 X 7.1 X 6 cm."

V3's last progress note dated 10/27/2021 05:45 PM reads R1 was transferred to the hospital for further treatment and debridement of R1's large necrotic ulcer. V3 wrote there was a high risk for osteomyelitis.

R1's "Skin Care" care plan dated 10/2021 reads R1 was incontinent of bowel and bladder. R1 needed extensive assist on bed mobility with more than two people assist. Skin care plan reads these were contributing factors to R1's skin issues. R1's comprehensive care plan does not include a care plan for R1's incontinence or bowel and bladder needs.

On 12/21/2021 at 2:09 PM, V8 (CNA, Certified Nurse Assistant) stated when V8 would start working at 06:30 AM, V8 would frequently find R1 soaked. V8 stated V8 complained to V9 (Nurse) and they would have to change R1 right away. V8 stated they would find R1's diaper, clothes, linen and wound dressings soaked. V8 stated when they turned R1, R1's wound dressing would fall out because it was "really soaked." V8 stated [V8] works full time doing eight hour shifts at the facility for almost seven years. V8 stated every morning when V8 came to work, R1 was soiled. V8 stated R1 would tell V8 that R1 would put on the call light during the night, and no one would come to clean R1.

On 12/21/2021 at 2:26 PM, V5 (Wound Nurse) stated R1 was "constantly wet", and the CNAs and staff needed to change R1 right away. V5 stated V5 informed staff to frequently check R1 for incontinence. Surveyor reviewed R1's comprehensive care plan with V5, who is also the MDS (Minimum Data Set) Nurse. V5 stated V5

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S9999	Continued From page 5	S9999		

does not read a care plan for R1's incontinence.

On 12/21/2021 at 2:56 PM, V9 stated V8 would frequently complain that R1 was left soaked from the previous shift. V9 stated V9 mostly works 7 am shift from Sunday to Wednesday at the facility. V9 stated 3 out of the 4 days, V8 and V9 would always find R1 soaked. V9 stated they found the sacral and buttocks wound dressings soaked. V9 stated almost every day when V9 came to work early, V8 would complain right away that R1 was soaked.

During a telephone conversation with V4 on 12/22/2021 at 10:29 AM, V4 stated constant moisture contributed to R1's pressure wounds getting worst. V4 stated R1 had a short penis and had difficulty using the urinal. V4 stated R1 would spill urine and it would wet the dressings, R1's sacrum, clothes and sheet. V4 stated it was a constant problem. V4 stated if staff changed R1 more frequently then R1 would do better but R1 refused.

Surveyor interviewed multiple staff members including V5, V6 (Nurse), V7 (CNA), V8, V9 and V10 (CNA). No mention of R1 refusing incontinence care. Reviewed R1's comprehensive care plan. It does not read that R1 had noncompliant behaviors for toileting.

During a telephone interview with V2 (Director of Nursing) on 12/22/2021 at 2:26 PM, V2 stated R1 was always incontinent. V2 stated the goal was to keep R1 dry at all times.

Surveyor reviewed facility's policy titled "Prevention of Pressure Ulcers" last reviewed 01/2017. It reads "Pressure ulcers are often made worse by continual pressure, heat,

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S9999	Continued From page 6	S9999		

moisture, irritating substances on the resident's skin (i.e., perspiration, feces, urine, wound discharge, soap resident, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition."
Under Interventions and Preventative Measures: Residents with Risk Factors, it continues to read:
"1. Risk Factor-Moisture
...
c. Provide clean, unwrinkled sheets
d. Place resident on a minimum of a q (every) 2 hour check and change program
e. Provide personal hygiene care/bath (teach staff to avoid leaving soap residue) to remove perspiration, bacteria and promote comfort. Frequency will be dictated both by facility routine and resident need. A resident who perspires profusely may need to receive more frequent care.
f. Address causes of moisture if possible (e.g., bladder training, schedule toileting)."
It further reads:
"6. Risk Factor - Bowel/Bladder Incontinence
a. Check resident for incontinence at least q 2 hours and clean skin where soiled.
b. Assess and treat urine leaks."

R2 is a resident of the facility. R2's face sheet reads diagnoses of Alzheimer's disease and dementia. R2's physician orders read an order for "Remedy Phytoplex Z-Guard (zinc oxide) 17 %-57 % topical paste (1) PASTEA (GRAM) Topical Notes: APPLY REMEDY Z-GUARD CREAM TO SACRUM, COVER WITH ½ ABD PAD AND TEGADERM FOR PROTECTION AND CUSHION." Order date is 03/29/2018. R2 also has an order for "SSD [silver sulfadiazine] 1 % topical cream (-) CREAM (GRAM) Topical Notes: Sacral Unstageable Pressure Injury -Cleanse with

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S9999	Continued From page 7 NSS [Normal Saline Solution]. Pat dry. - Apply SSD -Cover with gauze and ABD [abdominal] pad over -Secure with tape -Dress daily and PRN [as needed]." Order date 08/10/2021. R2 also has an order for an air loss mattress. On 12/21/2021 at 10:50 AM, surveyor observed V5 and V7 perform wound care for R2. R2's lower extremities are contracted. R2 was lying on a low air loss mattress. Surveyor observed fitted sheet on the mattress, flat sheet folded twice over (4 layers of flat sheet) and two blue disposable pads underneath R2. R2 was also wearing an incontinence product. V7 turned R2 and V7 removed the incontinence product. R2 with stool and no dressing noted over sacrum. V5 stated V5 did not see a dressing on R2's sacral wound. V5 stated R2 should have a dressing over R2's sacral wound. V5 proceeded with wound care. V7 provided incontinence care and V5 finished the wound care at 11:10 AM. Did not observe V5 place REMEDY Z-GUARD cream as ordered. During a follow-up interview with V5 on 12/21/2021 at 2:56 PM, V5 stated REMEDY Z-GUARD cream is a barrier cream to protect against moisture. V5 stated staff are to place it after each incontinence episode for R2. V5 stated V5 forgot to apply the REMEDY Z-GUARD cream for R2. On 12/21/2021 at 3:58 PM, V2 provided surveyor with facility's low air loss bed manufacturer print outs. V2 stated that standard of practice is one flat sheet on a low air loss bed. V4 reiterated this during a telephone interview on 12/22/2021 at 11:23 AM. V4 also stated during the interview that staff should continue applying the REMEDY Z-GUARD cream for R2 because it is used to protect the peri wound from wetness and from	S9999		

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S9999	Continued From page 8 stool. (B)	S9999		