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
	IL6014781	A. BUILDING: ______ B. WING ______	C 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2287490/IL151358 2287555/IL151431	S 000		
S9999	Final Observations 1 of 2 Licensure Violations 300.610)a 300.1210b) 300.1210d)2 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.

These Requirements were NOT MET as evidenced by:

Based upon observation, interview and record review the facility failed to ensure that the wound log was updated weekly, failed to ensure that wound care treatments are available, failed to sanitize the table prior to placing wound care supplies on it, failed to clarify (R2's) wound care orders, failed to follow (R6, R7's) wound care orders, and failed to administer treatments (daily) as ordered for three of three residents (R2, R6, R7) reviewed for pressure ulcers. These failures resulted in R2 sustaining a right gluteal/ischial pressure ulcer with bone exposure, wound infection and right buttock wound. R7 sustained a sacral pressure ulcer with bone and muscle exposure. R6 sustained a right (lateral) foot ulcer and infection. R2, R6, and R7's wounds required surgical intervention.
Based upon observation, interview and record review the facility failed to follow physician orders for one of three residents (R6) reviewed for pain. This failure resulted in R6's right foot dressing adhered to wounds, infection and foot pain rated 9/10.

Findings include:

On 9/26/22, the current wound log was requested

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S9999	Continued From page 2 V1 (Administrator) presented the weekly wound report dated 7/22/22-7/28/22 (dated roughly 2 months prior). On 9/26/22 at 1:22pm, surveyor inquired about the weekly wound log V3 (Nurse Consultant) stated (V5/Wound Care Nurse) "Didn't leave us anything so I have to start from scratch, see what's in PCC (Point Click Care - Electronic Medical Record) and develop a log from that." V3 affirmed that V5 quit about 2 weeks ago. R2's (7/5/22) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact). R2's (7/5/22) functional Assessment affirms (2 person) physical assist is required for bed mobility and transfers. R2's POS (Physician Order Sheet) includes but not limited (7/22/22) gentamycin sulfate ointment 0.1% apply to right gluteal fold every day for wound care, cleanse with 1/2 strength (treatment is excluded), pat dry, apply gentamycin, adaptic, cover with island dressing. (9/15/22) Medihoney gel apply to right gluteal fold every day for wound care cleanse with 1/2 strength dakin's, pat dry, apply medihoney/calcium alginate cover with dry dressing (start 9/15/22). On 9/26/22 at 1:28pm, surveyor inquired about R2's daily dressing changes R2 stated "Today would have been the 4th day it wasn't done but they did my wound care today, it's a must that they get done every day. I have a wound on my leg at the buttock, it's a big hole. The doctor that comes weekly, said your wounds are not being taken care of." R2's (September 2022) TAR (Treatment	S9999		

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S9999	Continued From page 3 Administration Record) affirms the right gluteal fold treatments were NOT documented on 9/2, 9/7, 9/9, 9/11, 9/12, 9/13, 9/15, 9/17, 9/18, 9/19, 9/20, 9/21, 9/23, 9/24, and 9/25 (15 out of 25 days). On 9/27/22 at 9:57am, V3 (Nurse Consultant) removed R2's right gluteal fold dressing, a (new) large right buttock wound was observed and actively bleeding. Surveyor inquired about the bleeding wound on R2's buttock V3 responded "The wound edge is bleeding, looks like a shear from the tape." Surveyor requested a description of R2's buttock wound V3 replied "It's open, I'm not gonna diagnosis it. I'm not a doctor." V3 changed R2's dressing, applied skin prep (which was not ordered) and covered the right gluteal fold with a bordered dressing however the edge of the dressing (with adhesive) was placed atop of R2's open/bleeding buttock wound. On 9/29/22 at 9:05am, surveyor inquired if skin prep was ordered for R2's gluteal fold treatment V15 (Wound Care Nurse Practitioner) responded "No." Surveyor inquired about potential harm if dressings are not changed (daily) as ordered V15 stated "If it's not being changed as ordered there's really high risk for infection because the biofilm keeps developing and the area around it can become macerated because excess drainage is not being absorbed." On 9/29/22 at approximately 3:25pm, surveyor inquired about the status of R2's right gluteal fold wound V16 (Wound Care Physician) responded it has been a chronic osteomyelitis wound and it's difficult to heal." Surveyor inquired about R2's treatment orders V16 stated "He (V3/Nurse Consultant) called me and told me that dressings were not available, so I changed the order" and	S9999		

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affirmed the call was received on or about 9/26/22 (survey start date).

R2's (9/8/22) physician wound assessment include right gluteal/ischial pressure ulcer with exposed bone. Infection: none. Procedure performed: excisional debridements - muscle.

R2's (9/26/22) POS affirms orders were received for Augmentin (Antibiotic) 500-125 mg three times daily for wound.

R7's (7/7/22) BIMS determined a score of 15 (cognitively intact).

R7's (7/7/22) functional assessment affirms extensive (2 person assist) is required for bed mobility and transfers.

On 9/26/22 at 1:25pm, R7 stated "I got a wound on the heel of my butt, last time I had wound care was last Thursday (4 days prior) when the doctor was here. It's supposed to be done every day."

R7's POS includes (5/25/22) collagen-antimicrobial sheet apply to sacrum every day for wound care. Cleanse with 1/2 strength dakins, pat dry, apply collagen and calcium alginate cover with foam dressing.

R7's (September 2022) TAR affirms daily treatments were NOT documented on 9/2, 9/5, 9/7, 9/9, 9/11, 9/12, 9/13, 9/14, 9/17, 9/18, 9/19, 9/21, 9/24, and 9/25 (14 out of 25 days).

On 9/27/22 at 9:47am, R7's sacral dressing was heavily soiled with a dark brown substance and only partially adhered to the skin. Surveyor inquired about concerns with R7's dressing V3 (Nurse Consultant) stated "It's soiled and

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undated." Surveyor inquired (again) when R7's dressing was last changed R7 responded "Last Thursday when the doctor was here" (5 days prior). R7's wound care orders were handwritten on a dressing package (present in the room). Wound care supplies were brought into R7's room however collagen and calcium alginate were not inclusive (as ordered). V3 removed R7's sacral dressing, cleansed the wound with 1/2 strength dakins, patted the wound dry, applied skin prep (which was not ordered), a foam dressing and border dressing. Surveyor inquired about R7's calcium alginate V3 responded "I don't know anything about that, I followed the order." Surveyor advised that calcium alginate was ordered for R7's wound (also written on the dressing) V3 replied "I'll redo it, I'll put the calcium alginate on it."

R7's (9/8/22) physician wound assessment includes sacral pressure ulcer with bone, muscle exposed. Procedures: excisional debridements removal of necrotic tissue, slough and biofilm.

On 9/29/22 at 9:31am, surveyor inquired about potential harm if calcium alginate and/or collagen were not applied to R7's sacral wound (as ordered) V15 (Wound Care Nurse Practitioner) stated "The purpose of the calcium alginate is to absorb exudate, so if it's not being used were not really managing the exudate. The skin could macerate and start becoming denuded."

On 9/29/22 at approximately 3:33pm, surveyor inquired about the status of R7's sacral wound V16 (Wound Care Physician) stated "His wound is stage 4 at least muscle. He (R7) had a surgical debridement."

R6's (7/6/22) BIMS determined a score of 13

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(cognitively intact).

R6's (7/6/22) functional assessment affirms (1 person) physical assist is required for bed mobility and transfers.

On 9/26/22 at 11:56am, R6 stated "The dressing on my foot it supposed to be changed every day but it's not. I went a whole week without them doing it. (V5/Wound Care Nurse) walked off about 2 weeks ago, now ain't nobody done nothing for my wound since then. One nurse just wrapped it up but didn't put nothing on it. Another nurse put betadine and wrapped it up that's it. They told me to put this other stuff on it cause they don't have nothing on the cart, that's what they said. They call themselves doing my dressing but don't put on nothing, no medicine." Surveyor inquired what "other stuff" he was referring to R6 presented iodosorb which was in his dresser and affirmed he received this from the hospital (not the facility).

R6's (September 2022) TAR affirms daily treatments to the right lateral foot were NOT documented on 9/2, 9/6, 9/7, 9/11, 9/13, 9/14, 9/17, 9/18, 9/19, 9/20, 9/21, 9/23, 9/24 and 9/25 (14 out of 25 days).

R6's (September 2022) POS includes (3/11/22) Right dorsal foot wound cleanse with 1/2 strength dakins, pat dry, apply betadine, cover with dry dressing daily. (7/15/22) Right lateral foot wound cleanse with normal saline solution, apply iodosorb with adaptic in peri wound daily.

On 9/26/22 at 12:17pm, surveyor requested to see R6's treatments V3 (Nurse Consultant) searched the treatment cart removed Dakins 1/2 strength solution and stated "It's house stock,

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S9999	Continued From page 7 there's no name on it." V3 then removed a half empty bottle of betadine (with another residents name) stated "It's not his" and affirmed R6's betadine was not available on the cart. V3 searched for R6's iodosorb to no avail and stated "I don't see one with his name on it." On 9/26/22 at 12:48pm, V3 returned to R6's room with an (unlabeled/opened) bottle of betadine, (unlabeled) bottle of 1/2 strength dakins solution, and R6's iodosorb (which was found in the wound care office). Surveyor inquired where the wound care laptop was located (to access the electronic treatment administration record) V3 responded "The prior ownership did not have them. The transition is not final yet, so there's nothing that we can do until its final with technology." V3 then walked behind the Nurse station and wrote down wound care instructions (on the back of a dressing package). V3 subsequently placed R6's wound care supplies on a visibly soiled over bed table. Surveyor inquired about concerns with R6's right foot dressing dated 9/24 (2 days prior) V3 replied "It says the 24th, todays the 26th." V3 attempted to remove R6's right foot dressing (calcium alginate covered with gauze - which were not the correct treatments) however it was stuck to both lateral wounds. Surveyor inquired about R6's dressing V3 responded "It looks like calcium alginate with gauze" however neither were ordered for R6's wound. V3 poured normal saline atop of R6's dressing and attempted to remove it slowly, a moderate amount of purulent drainage was noted, and the calcium alginate was adhered to the wound. Surveyor inquired about the appearance of R6's wound V3 stated "I see purulent drainage and alginate stuck on." Surveyor inquired if R6 was prescribed antibiotics for wound infection V3 replied "I don't think he is, I'm gonna call the doctor as soon as were done."	S9999		

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S9999	Continued From page 8 R6's (9/8/22) physician wound assessment includes right lateral foot excisional debridement. Removal of nectotic tissue, slough and biofilm. To promote healing and prevent infection. R6's (9/26/22) physician order note (entered 6:05pm) includes Bactrim DS (Antibiotic) 800-160 MG (milligrams) every 12 hours for wound (for 7 Days). On 9/29/22 at 9:21am, surveyor inquired about R6's (9/22/22) physician wound assessment V15 (Wound Care Nurse Practitioner) stated "There was moderate serous drainage from the wound." Surveyor inquired what purulent drainage is indicative of V15 responded "Purulent drainage is a sign of infection." Surveyor inquired about concerns with applying calcium alginate on R6's wound (instead of iodosorb as ordered) V15 replied "The purpose of the iodosorb is to reduce the slough and to soften the tissue. The calcium alginate absorbs." On 9/29/22 at approximately 3:29pm, surveyor relayed concerns regarding incorrect treatment applied to R6's right foot wound V16 (Wound Care Physician) replied "There was no order for calcium alginate, normally you put adaptic. I never ordered alginate on him." On 9/29/22 at 3:22pm, surveyor inquired about potential harm to residents if wound care orders are not followed V16 (Wound Physician) stated "If they are putting a totally different dressing or not doing the dressings wound can get infected. If they are putting something different there may be slowing of the healing." Surveyor inquired if R2, R6 and/or R7 required surgical intervention of aforementioned wounds V16 responded "All of	S9999		

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them (R2, R6, R7) have had debridement from me from time to time."

On 9/26/22 at 12:48pm, surveyor inquired about concerns with R6's right foot dressing dated 9/24 (2 days prior) V3 (Nurse Consultant) replied "It says the 24th, todays the 26th." V3 attempted to remove R6's right foot dressing (calcium alginate covered with gauze - which were not the correct treatments) however it was stuck to both lateral wounds. Surveyor inquired about R6's dressing V3 responded "It looks like calcium alginate with gauze" however neither were ordered for R6's wounds. V3 poured normal saline atop of R6's dressing and attempted to remove it slowly, a moderate amount of purulent drainage was noted, and calcium alginate was adhered to the wound. V3 stated "I see purulent drainage and alginate stuck on." V3 replied "I don't think he is(on antibiotics), I'm gonna call the doctor as soon as were done." Immediately after V3 completed the dressing change, R6 reported right foot pain.

R6's (9/26/22) physician order note (entered 6:05pm) affirms Bactrim DS (Antibiotic) was prescribed for wound.

On 9/29/22 at 9:21am, surveyor inquired about R6's (9/22/22) physician wound assessment V15 (Wound Care Nurse Practitioner) stated "There was moderate serous drainage from the wound." V15 stated "Purulent drainage is a sign of infection."

On 9/29/22 at approximately 3:29pm, surveyor inquired about potential for harm to a resident if a wound becomes infected V16 (Wound Physician) stated "It could cause pain."

R6's (9/13/22) MAR (Medication Administration

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Record) affirms that Tylenol 500mg was administered at 3:08am for pain rated "9." R6's pain assessment follow-up is not documented as warranted.

The (undated) preventive skin care policy stated good skin care is provided by staff on each shift and as necessary. Medicated treatments ordered by the physician are to be applied by the licensed nurse as appropriate.

The (undated) management of pain policy states pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The physician will be notified of resident's complaint of pain when not relieved by medication as ordered by the physician. Thorough communication with the physician will ensure an appropriate pain management plan. Document on the back of the MAR/pain flow sheet the effectiveness of pain medication. Effectiveness should be measured 1-2 hours after administration.

(A)

2 of 2 Licensure Violations
300.3240a)
300.32400b)
300.3240c)
300.3240d)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility

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S9999	Continued From page 11 administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These requirements were not met as evidenced by: Based upon record review and interview the facility failed to report IOUO (Injury of Unknown Origin) to IDPH (Illinois Department of Public Health) within regulatory requirements and failed to submit accurate information to IDPH for one of four residents (R1) reviewed for abuse. Findings Include: On 9/19/22, IDPH (Illinois Department of Public Health) received allegations that the facility was notified of R1's (9/14/22) upper lip and left cheek swelling (due to unknown origin). R1's (9/15/22) history and physical states per family patients face is swollen, droopy and she's not acting correctly. Last known normal was 8pm yesterday when they (family) left the nursing home. On 9/26/22 at 3:17pm, surveyor inquired about R1's (9/14/22) IOUO V1 (Administrator) stated "I can't find a incident for her." Surveyor advised that IDPH received allegations regarding R1's	S9999		

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S9999	Continued From page 12 IOUO including upper lip and left cheek swelling sustained on or about 9/14/22 V1 responded "I'll check into it." On 9/26/22 at 4:15pm, surveyor inquired about R1's (9/14/22) IOUO including upper lip and left cheek swelling V3 (Nurse Consultant) advised that he (V3) was the interim DON (Director of Nursing) at that time however was unaware of the allegation. Surveyor inquired about the regulatory requirement for IOUO V3 stated "We (staff) should notify the doctor, family, DON and administrator" [IDPH notification was excluded]. On 9/28/22 at 2:00pm, surveyor inquired about R1's (9/14/22) IOUO V1 responded "I think I told you on Monday (9/26/22) I couldn't find the actual document. It was reported to IDPH, I just can't find it here." Surveyor inquired who reported R1's (9/14/22) IOUO to IDPH V1 replied "It was reported by the interim DON (V3)." Surveyor inquired about the regulatory requirements for IOUO V1 stated "You have to report it to IDPH within an hour." On 9/28/22 at 2:11pm, surveyor contacted V18 (IDPH Clerical) who affirmed that the department did not receive any reportable incidents from the facility involving R1 on or about 9/14/22. On 9/29/22 at 1:58pm, surveyor relayed that IDPH did not receive any documentation regarding R1's (9/14/22) IOUO V1 responded "I don't think that was a reportable though." On 9/29/22 at 2:51pm, V1 presented R1's facility reported incident which states Incident Date: 9/29/22 (the incident occurred on 9/14 - 15 days prior). It was reported by the State Surveyor that resident was reported to the department for	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014781	A. BUILDING: ______ B. WING ______	C 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 having an injury on 9/14/22 of an upper lip and left cheek swelling. Allegation of injury was not previously made known to the facility (the facility was made aware of the allegation on 9/26/22 - 3 days prior). The incident was reported to IDPH via smartsheet on 9/29/22 at 2:49pm. The (undated) abuse prevention program states all personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, including injuries of unknown origin. When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately: State Licensing and Certification Agency (ie: Department of Health). The investigator will submit a final report of the conclusion of the investigation in writing within five (5) working days of the incident. (C)	S9999		