STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009112	A. BUILDING: _____ B. WING _____	05/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL HOUSE & HEALTH CR CTR	3800 NORTH CALIFORNIA AVENUE CHICAGO, IL 60618

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1)2)3) 300.1210d)5) 300.3220f) 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 practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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. 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	S9999		

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S9999	Continued From page 2 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 observation, interviews and record review the facility failed to follow their pressure injury policy in relation to performing treatment as ordered by physician, documentation on treatment administration record (TAR), and failed to assess newly identified skin opening areas for 2 residents (R10 and R71) reviewed for pressure injuries prevention and treatment. These facility failures resulted in R10's facility acquired sacral pressure ulcer reopening and increased from stage 2 to stage 3 and lack of assessment of R71's newly identified skin opening. Findings include:	S9999		

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S9999	Continued From page 3 On 05/10/2022 at 12:40 PM, R10 was seen in her room alert and verbally responsive. R10 was able to express her thoughts well during conversation. R10 said that she has wound on her back and that the wound had been there for quite some time. On 05/12/2022 at 12:01 PM, V13 (Wound Nurse Coordinator / Registered Nurse) stated that she started in March 2022 and was trying to keep updated of all the resident wounds in the facility. V13 stated that R10 has 2 pressure injury sites: Left lower leg and sacrum. Both are stage 3 and the dressing treatment was changed on 5/11/2022 from Santyl to Calcium Alginate with Silver. V13 said that V24 (Nurse Practitioner/ Wound) came to see R10 on 5/9/2022. V13 could not answer why the wound assessment done by V24 dated 5/9/2022 the treatment performed and recommended by V24 was Santyl for 30 days. V13 was asked about R10's Treatment Administration Record (TAR) related to multiple treatment orders that was not documented as being performed on multiple dates. V13 was not able to address the question. V2 then stated that R10's sacral pressure wound started with an abrasion and later increased to stage 3. Both V13 and V2 (Director of Nursing) said that if a treatment was not documented it was not performed. V13 stated that pressure injury/wound treatment and dressing changes must be followed to facilitate healing. V13 further stated that lack of following treatment orders will lead to pressure injuries not healing. On 05/12/2022 at 3:13 PM, R10's sacral pressure injury was observed with V2 (Director of Nursing), the approximate size measured 3 X 2 X 1.0 centimeters (Length X Height X Depth)	S9999		

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S9999	Continued From page 4 which fits the description of a Stage 3 pressure injury. Fatty tissue can be seen and slough about 5% at the center of the wound. V2 said, "Yes, I agree this is stage 3." The left lower leg pressure injury was observed with slough at the center of the area. Per facility assessment dated 3/17/2022, R10's facility acquired sacral pressure injury was first identified on that same date. R10's sacral pressure injury was staged as 2 (which defines as breaking of the skin top layer) with measurement of 1.8 X 1.0 X 0.1 centimeters with serous drainage. Based on the (TAR) for March 2022, R10 has the following orders to apply Hydrocolloid sheet dressing 3 times per week, and as needed after cleansing with normal saline one time a day for coccyx wound. Treatment Administration Record (TAR) documents that on 3/2, 3/3, 3/7, 3/8, 3/15, 3/16, & 3/17/22 (3/17/22 the day sacral pressure injury reopened and was first identified), 3/23 & 3/25/22 treatments was not documented as completed. Per facility assessment dated 3/24/2022, R10's sacral pressure injury increased from stage 2 to stage 3 with increase in measurement of 2.0 X 1.5 X 0.1, serous drainage, 75% yellow slough. For the month of April 2022, the same treatment of Hydrocolloid sheet dressing for sacral pressure injury was not performed on the days of 4/5, 4/6 and 4/8/22. The treatment order was discontinued on April 8, 2022, after R10 was seen by V24 on 4/7/2022. The treatment order was changed to Medihoney dressing from 4/9 to 4/20/22. The treatment for the sacral wound per TAR documentation was not documented on 4/12, 4/13, 4/14, 4/15 and 4/20/22 as being performed. On April 15th to the 20th Gentamicin Antibiotic ointment was added as an order for the sacral wound, however it was not documented as given	S9999		

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S9999	Continued From page 5 on April 15th and 20th. On April 21st to the 27th the treatment order was changed to Santyl Ointment and was not documented as being done for 4/22, 4/26, & 4/27/22. Multiple dates on both the March and April 2022 TAR were not documented as being performed. The most current wound assessment by V24, dated 5/9/2022: Stage 3, size 3.3 X 3 X 0.5 centimeters an increase in size and staging. 5/13/2022 at 9:38 AM. V24 (Nurse Practitioner/Wound) stated that R10 has two pressure injury sites on the sacral area and left lower leg. Per treatment records there are multiple orders for treatment and must be performed as ordered. V24 said, "When the treatment is not performed as ordered, the pressure ulcer will be become worse, and infection will happen." V24 said that the first time he saw R10's sacral pressure injury was on 4/7/2022. When V24 comes and assesses R10, V24 performs treatment and dressing change. V24 said, "R10 sometimes does not want to be turned at the beginning of the dressing change. In my experience once you explain to her and do health teaching, R10 allows you to do treatments. Yes, during all my visits the treatment was performed to R10." V24 further said, "Infection can set in because of the proximity of R10's sacral pressure injury with her anus (rectum) that is why I ordered Gentamicin antibiotic ointment. They need to resolve this issue of treatment not being performed as documented. Because if not documented it was not performed." R71 was 101 years old, admitted to hospice with medical diagnosis that includes Dehydration, Hypertensive heart.	S9999		

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S9999	Continued From page 6 On 05/10/2022 at 12:38 PM. R71 was lying on a low air loss mattress with multiple sheets. R71 was alert and verbally responsive. R71 seemed uncomfortable turning her head from side to side. On 05/11/2022 at 1:26 PM. With V13 (Wound Nurse Coordinator / Registered Nurse) assisted by V16 (Registered Nurse) performing treatment or dressing change to R71. R71 has 2 wound sites; Sacral and left dorsal foot. During dressing change of the mid-sacral area pressure injury, another site was identified approximately 2 centimeters lower left from the mid-sacral pressure injury. The newly identified opening was reddened and open superficially to the skin with small bleeding. V13 was asked if the opening was new or if it was there prior. V13 stated that it was not there before. V13 then covered both areas with the same dressing. During the dressing change R71 was screaming repeatedly, "Water! Water! I need water." There was no pitcher, no glass or cup available in the room. V13 stated that she will bring R71 water after dressing change. Then R71 started grimacing and again turning her head from side to side. R71 said repeatedly, "It hurts, don't be rough" even when V13 was not or barely touching R71. V13 told R71 that she will give R71 pain medication after the treatment. After the treatment was completed V13 went to R10's room for another Treatment scheduled at 2:00 PM. V16 went back to the Nurse's Station and sat in the chair. None of the staff gave R71 water as requested. On 05/12/2022 at 12:01 PM, with V13 (Wound Nurse Coordinator / Registered Nurse) and V2 (Director of Nursing). V13 stated that she did not assess that newly identified opening near R71's sacral pressure injury. V13 was asked the reason why an assessment was not completed upon	S9999		

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S9999	Continued From page 7 identification of wound, no information was given. V13 stated that she will assess it today. R71's Facility Wound Assessment dated 4/29/2022 notes the sacral pressure injury was first identified in the facility on that same date. Measurement 3 X 2.5 X 0.1 centimeters. Assessments dated 4/28/2022 and 5/6/2022 documents that R71 was in pain during assessment. The care plan for pain with target date 7/7/2022 documents: Administer analgesia (Tylenol / Lidocaine) as per orders. Give 30 minutes before treatment or care. R71's Medication Administration Record (MAR) for April and May 2022 has an order for Acetaminophen (Tylenol) 325 MG to be given 2 tablets as needed for pain and Acetaminophen Suppository 650 MG. There was no documentation on the MAR that the pain medications were given. Facility policy on Pressure Ulcer Treatment and Management not dated. Reads in part: Objective is for residents who receive treatment for pressure ulcers. Under guidelines: The licensed nurse will document the treatment as given on the Treatment Administration Record (TAR). Facility policy on Wound Cleansing not dated. Reads in part: It is the policy of this facility to cleanse all wounds in order to clear exudates, bacteria contamination, and debris from the wound bed. This process is done since optimal healing cannot proceed until the inflammation-producing substances are removed from the wound surface. Wound cleansing will be done as indicated in the physician's order by a licensed nurse. Under procedure, document on the Treatment Administration Record (TAR). Facility policy on Pressure Ulcer Risk	S9999		

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S9999	Continued From page 8 Assessment Policy and Procedure not dated. Reads in part: It is the policy of this facility to assess all residents for additional factors that place them at risk for developing pressure ulcers. (B)	S9999		