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
	IL6010086	A. BUILDING: ______ B. WING ______	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF PALOS HILLS	10426 SOUTH ROBERTS PALOS HILLS, IL 60465

(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 Complaint Investigations: 2297641/IL151532 2298569/IL152663 2298488/IL152561	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.1010h) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1210d)3) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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**	

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 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. 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: 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. These requirements were not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to inform a physician of the onset of a resident's change of condition (R227), failed to monitor a resident's vitals as ordered (R227), failed to monitor blood sugars levels for residents with diabetes (R220 and R227). This failure affected 2 of 52 sampled	S9999		

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S9999	Continued From page 2 residents. As a result, R227 was unable to be aroused by staff for over 5 hours (6:38AM-12:26PM) and experienced decreased oxygen levels before nursing/medical interventions were given. Findings include. 1. According to a face sheet, R227 is an 83-year-old male with diagnoses of history of Diabetes Mellitus, Myocardial Infarction, Dementia with Behavioral Disturbance, Atrial Fibrillation, Peripheral Vascular Disease, and chronic kidney disease, who was originally admitted to the facility 10/27/2022. R227's physician progress note dated 10/31/2022 12:37PM documents: pulmonary follow-up: he was sitting in a recliner chair at the nursing station, Full Code status, patient recovering after heart attack related to partial blood vessel blockage and has underlying blood flow restriction related cardiomyopathy (heart muscle disease), diabetes and hyperlipidemia. Does not offer new symptoms today, Vital signs remained stable, Oxygen saturation is good. Examined to be awake and confused. R227's current physician order sheet documents he is full code and documents an active order effective 10/27/2022 for vital signs (blood pressure, temperature, pulse, respirations, and oxygen saturation) to be measured every shift daily. R227's current care plan included the following: Transfer to hospital and/or intensive care unit if indicated; R227 is at risk for signs/symptoms including Hypoglycemia, Hyperglycemia, or	S9999		

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Uncontrolled diabetic status related to diagnosis of Diabetes Mellitus with interventions including blood sugar measurements as ordered. Administer medication as ordered. Monitor vital signs during routine care and notify physician of abnormal findings; R227 has potential risk for altered cardiac function related to diagnosis of Atrial Fibrillation, Coronary Artery Disease, Hyperlipidemia, and Ischemic Cardiomyopathy with interventions including. Give meds for hypertension and document response to medication. Monitor blood pressure. Notify physician of any abnormal readings; R227 is at risk for complications including fluid volume overload related to diagnosis of Stage 3 Chronic Kidney Disease with interventions including: Monitor changes in mental status - Lethargy; Somnolence; Fatigue. Monitor for signs and symptoms of fluid overload or fluid loss. Monitor vital signs as ordered. Monitor/document/report to physician the following signs and symptoms: difficulty breathing (Dyspnea); increased heart rate (Tachycardia); elevated blood pressure (Hypertension); skin temperature; peripheral pulses; level of consciousness.

On 11/01/22 from 11:21 AM - 11:45 AM the surveyor observed V22 (Agency Certified Nursing Assistant - CNA) enter R227's room to provide care. R227 was noted to be non-responsive to several attempts from V22 to stimulate him by calling his name, touching his arms, legs, and repositioning him for incontinence care. R227 did not open his eyes during these activities and move his arms very little when firmly touched. V22 stated R227 did not rouse when she took his vitals earlier in the morning. V22 repositioned R227 and provide incontinence without rousing him. V22 stated she doesn't even think R227 ate breakfast because he could not be roused. V22

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stated she's not sure how R227 even received medication in his current condition. V22 stated R227 had been unresponsive since she started working at 6:38AM and didn't even rouse when she took his blood pressure earlier in the morning.

On 11/01/22 at 12:26 PM V25 (Registered Nurse) entered R227 room. V25 reported she gave R227 medication this morning and he opened his eyes for her. V25 stated she called his name multiple times, but he won't rouse. At the time of the observation, V25 reported R227's oxygen levels were at 64 and fluctuating and he needed oxygen. V25 left R227's and return to the room with an oxygen tank. V26 (Nurse Manager) came into R227's room to measure his oxygen levels with the fingertip oxygen measuring device.

On 11/01/22 at 12:34 PM while in R227's room, V25 (Registered Nurse) and V26 (Nurse Manager) administer oxygen to R227. V25 stated R227's oxygen levels are going back up. V25 stated R227 was lethargic this morning. V25 stated she was trying to get ahold of the physician. V25 stated V26 called the doctor for instructions, we'll wait five minutes for her to call back and if she doesn't respond in that time frame, we'll call 911. V25 stated she was informed by V22 (Certified Nursing Assistant - CNA) this morning R227 was not able to be roused. Observed R227 to remain unresponsive to stimuli while receiving oxygen.

On 11/01/22 at 12:52 PM the surveyor observed R227 to remain unresponsive to stimuli while being taken by paramedics to the hospital. V25 (Registered Nurse) reported R227's oxygen saturation was fluctuating between 50-64% when she initially assessed him at 12:26PM.

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Continued From page 5

On 11/01/22 at 01:02 PM V22 (Agency Certified Nursing Assistant) stated at 10:51 this morning (15-20 minutes before encountering the surveyor) she informed V25 (Registered Nurse) that R227 could not be roused when she took his blood pressure earlier in the morning.

On 11/01/22 at 01:13 PM V25 (Registered Nurse) stated R227's initial oxygen levels were at 94 and his respirations at 17 when she assessed him in the morning while giving him medication between 8:30 AM - 9:00 AM. V25 stated she was alarmed by that oxygen level because she prefers it to be at least 95 and over so she wrote down all R227's other oxygen levels. V25 stated V22 informed her twice that R227 was lethargic and didn't want to get up. V25 stated because of what was reported to her by V22, she checked in on R227 multiple times, entered his room at least twice and rubbed the center of his chest firmly to rouse him and he would open his eyes. V25 stated when giving R227 medications in the morning he opened his eyes and turned his head although he didn't say much. V25 stated when V22 informed her the 2nd time about not being able to rouse R227, she then went in his room to check on him. V25 stated she did not inform the physician about the difficulty arousing R227 and wishes she would have. V25 stated she didn't notify the physician because R227's blood pressure and heart rate were normal. V25 stated she assumed R227 was not responding to her attempts to rouse him by calling his name because he was hard of hearing. V25 stated it's not normal to have to firmly rub an individual's chest to rouse them regardless of whether they are hard of hearing or not.

R227's vital measurement reports from 10/28/2022 - 11/01/2022 document the following:

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S9999	Continued From page 6 -no oxygen saturation, respirations, or temperature measurements for 10/29/22 and 10/31/22, one oxygen saturation, respiration, temperature measurement 10/28/22 and 10/30/22, no pulse measurement 10/29/2022, one pulse, and one blood pressure measurement 10/28/22, 10/30/22, and 10/31/22. -from 10/28/22 - 10/30/22 low - normal blood pressure levels, and on 10/31/22 elevated blood pressure level of 132/67. -on 11/01/22 at 07:45AM a 94% oxygen saturation level with room air, pulse rate of 98 beats per minute (noted as not applicable), blood pressure rate of 139/77; at 12:27PM a 64% oxygen saturation level with room air, pulse rate of 88 beats per minute (noted as unable to determine), and blood pressure level of 164/79. R227's progress note dated 11/1/2022 12:25PM (created at 5:08PM) documents: Writer observed resident unresponsive, color ashen, lips bluish tinged, oxygen saturation 64% room air. Manager notified. Oxygen via nonrebreather applied at 6L, oxygen saturation increased to 99% within 2-3 mins. Physician notified per manager. Received order to send resident out via emergency medical services. R227's progress note dated 11/1/2022 12:32 (created at 6:06PM) documents: order received by physician to transfer him to hospital emergency room via 911 emergency medical transportation. R227's progress note dated 11/1/2022 12:45 (created at 5:11PM) documents: Paramedics here, resident sent to hospital emergency room with appropriate paperwork. R227's progress note dated 11/2/2022 12:56AM	S9999		

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S9999	Continued From page 7 documents: patient admitted to the hospital with diagnose of Urinary Tract Infection (note not provided by facility). On 11/03/22 at 03:51 PM V35 (Medical Director) stated when a resident who is alert and oriented has a change in condition the nurse should notify either the Director of Nursing, Assistant Director of Nursing, or their physician. V35 stated if a resident was alert and interactive and becomes unresponsive to a sternal rub then there is a change of condition and their vital measurements such as pulse, oxygen saturation, and blood sugar should be assessed. V35 stated in a change of condition such as this there are many ways to determine the possible causes of their change in condition. On 11/04/2022 from 2:46PM - 3:25PM V2 (Director of Nursing) stated R227's vitals should be taken every shift and include blood pressure, respirations, pulse, temperature, and oxygen saturation. V2 stated R227's blood pressure on 10/30/22 was elevated compared to previous days. V2 stated R22's 7:45 AM and 12:27PM blood pressure levels on 11/01/22 was elevated compared to his previous ones. V2 stated R227's blood oxygen saturation 11/01/22 at 12:27PM was abnormal at 64%. V2 stated there is an issue with not following orders to monitor changes in R227's vital signs by not ensuring his vitals were measured each shift daily. V2 stated since R227 was still not responding to stimuli when his oxygen levels increased while receiving oxygen, there should have been an emergency transfer. V2 stated responsiveness would include eyes opening and responding appropriately to stimuli such as responding to his name being called or to touch. V2 stated emergency transfers would include calling 911 while performing interventions	S9999		

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S9999	Continued From page 8 which is part of the facility's emergency management policy. V2 stated as soon as V22 (Agency Certified Nursing Assistant) notified V25 (Registered Nurse) of R227's change in condition of non-responsiveness he should have been immediately assessed by the nurse which would have included taking all his vital signs and checking his responsiveness to his name being called and being touched. V2 stated it is not normal to have to firmly rub a resident's chest to rouse them. 2. R220 is an 83-year-old male with a diagnosis of Diabetes Mellitus with Diabetic Neuropathy, Metabolic Encephalopathy, Acquired Absence of Left Leg Above Knee, Gangrene, and Sepsis with Septic Shock who was originally admitted to the facility 10/27/2022. R220's current care plan does not include diabetic care. On 10/31/22 at 11:25 AM V27 (Family Member) reported R220 is supposed to receive morning insulin. V27 stated R220s's blood sugar levels during breakfast were measured by a student nurse to be at 272. V27 stated at around 8:30AM R220 ate a muffin, oatmeal and drank apple juice for breakfast and hasn't received insulin. R220's current physician order sheet documents an active order effective 10/27/2022 for injection of 34 units insulin under skin daily at bedtime for diabetes mellitus, an active order effective 10/30/2022 for insulin injection underneath skin before meals and at bedtime per sliding scale blood sugar measurements for diabetes mellitus due to underlying condition with diabetic neuropathy; no blood sugar measurements included in orders.	S9999		

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R220's October 2022 Medication Administration Record documents he did not receive ordered 34 units insulin injection at bedtime on 10/28/22 as ordered; did not receive ordered insulin injection administration per sliding scale blood sugar measurement in the late afternoon/evening and at bedtime on 10/28/22 as ordered; in the late afternoon/evening on 10/30/22, and in the morning and afternoon on 10/31/2022.

R220's blood sugar measurements from 10/28/22 - 10/31/2022 documents multiple measurements of 200's to 300; no blood sugar measurements in the late afternoon/evening or at bedtime 10/28/2022; blood sugar levels of 358 on 10/28/2022 at 11:31AM, 271 on 10/30/2022 at 5:19PM, 172 on 10/31/2022 at 9:40AM, 322 on 10/31/2022 at 11:14AM.

On 11/03/22 at 11:34 AM V2 (Director of Nursing) reported that there were two missed blood sugar reading documentations for R220 on 10/28/2022.

According to the face sheet R227 is an 83-year-old male with a diagnosis of a history of Diabetes Mellitus., R227 was originally admitted to the facility 10/27/2022.

R227's current physician order sheet documents had an active order effective 10/27/22 for injecting 16 units of insulin every 12 hours for diabetes - notify physician if blood sugar levels are below 60 and over 300; an active order effective 10/29/22 for injecting 16 units of insulin before meals and at bedtime for diabetes - notify physician if blood sugar levels are below 80 or over 200. No orders were included for blood sugar measurements.

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S9999	Continued From page 10 R227's progress note dated 10/29/2022 5:30PM documents: Physician in facility today with new orders for blood sugar measurements 4 times per day. Orders carried out. R227's blood sugar measurements from 10/28/22 - 10/31/22 documents one blood sugar measurement from 10/29/22 - 10/31/22, blood sugar levels of 272 on 10/28/2022 at 8:39AM, 222 on 10/28/2022 at 11:35PM, 286 on 10/30/2022 at 5:45AM, 239 on 10/31/2022 at 6:25PM. On 11/04/2022 from 2:46PM - 3:25PM V2 (Director of Nursing) was interviewed. The information included but not limited to the following: V2 reported, she did not see an order for R220's for blood sugar measurements and does not see one for R227. V2 stated they R220 and R227 should have orders for blood sugar measurements, however they should have blood sugar checked each time they receive their insulin. V2 stated if blood sugars are not measured as ordered for residents there is no way to appropriately assess changes in levels so the physician can be notified to address the changes. V2 stated, R220 not receiving insulin as ordered could result in altered blood sugar levels which could contribute to high blood sugar levels. (A) Statement of Licensure Violations (2 of 3): 300.610a) 300.1010h) 300.1210b)	S9999		

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S9999	Continued From page 11 300.1210d)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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999		

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S9999	Continued From page 12 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. 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 requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to prevent and treat pressure ulcer/pressure injury (PU/PI) development for residents who were at increased risk for PU/PI development, failed to provide ongoing skin assessments for the residents, failed to provide proper treatment to prevent worsening of pressure ulcers or infection and provide appropriate pain management. These failures affected four of four residents (R39, R228, R269 and R377) identified with issues concerning	S9999		

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(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
S9999	Continued From page 13 pressure ulcer or injury. As a result, R269 and R377 were admitted without pressure ulcers and developed infected pressure ulcers while at the facility. In addition, R377 death was linked to sacral osteomyelitis. Findings include: 1. R269 is a 79-year-old male who was admitted to the facility on 10/12/2022 with past medical history including, but not limited to unspecified protein-calorie malnutrition, metabolic encephalopathy, nonchronic ulcer of unspecified part of unspecified lower leg with unspecified severity, urinary tract infection. 10/31/20222 at 12:45PM, resident's son came to the dining room during lunch and stated that he would like to speak to someone regarding his father, R269. V4 (Family member) stated that he thinks his father is being neglected, he does not like the condition he found him in. Surveyor went to the room with V4 and V6 (nurses). Upon entering R269's room, the surveyor noted a strong smell of urine and feces. R269 had indwelling catheter draining via gravity and some dark yellowish colored urine. R269 was lying on a regular mattress and did not have any heel boot applied, contracture noted to R269's left hand that was placed on a pillow. V6 (nurse) said that the urine is more yellow in color than the last time she saw the resident, she will call the doctor and let him know. V5 (C.N.A/certified nurse aide) was called to the room and she said that she is the assigned C.N.A for the resident but she has not had the time to check him today. V6 was asked to pull the blanket on the resident and resident was noted with a big bowel movement stuck to his butt and on the bed cover. R269 not have any adult	S9999		

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S9999	Continued From page 14 brief. R269 also noted to have wound dressing on the buttocks that was saturated with drainage and brown in color. 11/01/22 at 9:15AM, the surveyor observed dressing change for R269 with V7 (wound care nurse). V7 said that R269 has two pressure ulcers and both are facility acquired. She described them as an unstageable pressure ulcer to the left buttocks and a Deep Tissue Injury (DTI) to the right hip. V7 said that she became aware of the pressure ulcers on 10/30/2022. V7 removed the dressing on the left buttock and there was a large area of excoriation with greenish brown drainage that has a foul smell. V7 said that the wound care doctor has not seen the resident. V7 added that she will ask the nurse to call and get some antibiotics for the resident because the wound looks like it is infected. On the resident's right hip is a large area of breakdown that is brownish ping in color. V7 said that she will change the current treatment and use collagen with foam dressing, the current treatment is peeling off his skin. Surveyor asked V7 if they can just change the order without calling the doctor and she said that she is just using her judgement and she will call the doctor and inform him, when he makes rounds, he can change the treatment again if needed. V7 added that she ordered an air loss mattress and foam boots for resident. Resident was placed on oral antibiotics for wound infection as indicated in physician order dated 11/01/2022 that shows an order for Augmentin Tablet 875-125 MG (Amoxicillin-Pot Clavulanate) give 1 tablet by mouth two times a day for wound for 7 Days. Braden scored assessment dated 10/12/2022 coded R269 as a 13, moderate risk for pressure sores. Nursing admission assessment dated	S9999		

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10/12/2022 documented pain to the right lower leg and toe, and pain to the left lower leg and toe. Skin condition was documented as normal, with old scabs and dryness to the lower extremities.

Physician order dated 10/12/2022 shows the following weekly skin screen (Complete skin screen form if new alteration is present) every day shift every Tue, Thu, Sat. Activities of Daily Living (ADL) care plan dated 10/12/2022 reads: Resident requires assist with daily care needs r/t dx/hx of AMS, HTN, CKD, Glaucoma, HTN, benign prostatic hyperplasia with lower UTI. Resident is a total assist of two staff members for bed mobility, toileting and transfers Interventions include: Assist resident with ADLs, encourage/ assist with turning and repositioning every two hours and as needed, Hoyer lift with two assists for transfers. Review of records did not show any care plan or interventions in place for alteration in skin integrity for the resident.

R269 Minimum Data Set (MDS) dated 10/19/2022 coded R269 as 4/3 indicating total dependence with 2 persons physical assist for bed mobility and transfer, 3/3 (Extensive assist with one- person physical assist for dressing, toilet use and personal hygiene and 2-person physical assist for bathing. Section H of the same assessment coded resident as always incontinent of bowel.

11/03/22 at 3:34PM, V35 (Medical Director) said that that he is not aware of the increased number of facilities acquired pressure ulcers. V35 stated the staff should be doing skin assessment on residents as ordered by the physician and the attending physicians should be rounding on the residents. V35 was asked how often the attending physicians are expected to see residents and he

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S9999	Continued From page 16 said that it varies and depends on cases. He added that the resident's nutritional status should also be monitored as that can also affect wound healing. V35 said that preventive measure like turning and repositioning, daily skin assessment during showers/baths and air loss mattress could help to avoid development of pressure ulcer. V35 stated he will discuss with the DON to see how to deal with the issue. Facility skin care prevention policy with a review date of 1/2022 presented by V2 (DON) stated in part that all residents will receive appropriate care to decrease the risk of skin breakdown. Under guideline the same document states that the nursing department will review all new admissions/readmissions to put a plan in place for prevention based on resident's activity level, comorbidities, mental status, risk assessment and other pertinent information. For residents who are bed or chair bound, provide a chair cushion and pressure reducing mattress. Another document presented by V2 (DON) titled skin management, monitoring of wounds and documentation dated 01/2022 states: it is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. ///// 2. R377 was a 72 year old female admitted to the facility 9/17/2018 with diagnoses that included Dementia, Hypertension, Cerebral Infarction and Dysarthria and Anarthria. According to Minimum Data Set (dated 8/28/22), R377 had mild cognitive impairment with a BIMS score of 10. R377 had a functional assessment requiring	S9999		

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S9999	Continued From page 17 extensive 2 person physical assistance with transferring and toileting; required extensive 1 person assist with bed mobility and was incontinent of bowel and bladder function. Timeline according to progress notes and physician order sheets: 5/16/22: R377 developed Moisture Associated Skin Dermatitis (MASD) to sacral area. Order placed for Zinc Oxide barrier cream to the sacrum three times daily and as needed. This order was later discontinued 9/7/22 8/5/22: V36 Wound care coordinator noted shearing MASD to Sacrum. New order placed to clean sacrum with normal saline, pat dry and apply zinc oxide barrier cream and applu foam dressing three times weekly and as needed. 8/11/22: NP ordered Augmentin suspension for 7 days due to elevated White Blood Count of 12.04 and multiple blisters presenting over axilla and breast. 8/13/22: Nurse charted no new skin concerns during bathing 8/26/22 Assessed by V36 Wound Care coordinator with MASD with intact blister to sacrum. No new orders placed with continued use of Zinc barrier cream. 9/6/22: Nurse noted blister to sacrum ruptured and notified wound care team. 9/7/22: V36 wound care coordinator assessed sacrum with ruptured blister, slough tissue, and granulation tissue with odor. Placed orders for air loss mattress and wound care consult. Treatment orders placed to cleanse with normal saline, apply honey and cover with foam dressing three times weekly and as needed. 9/8/22: Seen by Wound care MD; assessed sacrum wound as unstageable. Debridement and culture taken at the bedside.	S9999		

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S9999	Continued From page 18 Augmentin antibiotic ordered by Infectious Disease Nurse Practitioner for multiple blisters. Does not address sacral wound within progress notes. Nursing staff note that resident accepts antibiotic and supplement despite refusing other meds per baseline behavior. V36 Wound care coordinator revised order to cleanse with Dakin's Solution, rinse with normal saline and apply honey with foam dressing three times weekly and as needed. 9/17/22: No treatments administered to the sacrum according to Treatment Administration Record. No further wound care notes or observations identified in resident chart 9/22/22: Seen by V38 Nurse Practitioner who ordered CBC and CMP to be collected in the AM. V37 Wound coordinator ordered Dakin's solution soak to sacral wound with dry dressing daily. 11:41AM Nurse received orders to send Resident to the hospital for sacral wound infection debridement. 1:15PM Resident transferred via ambulance to hospital. Did not return to the facility. Expired on 10/25/22 at hospital with primary diagnoses of sacral osteomyelitis. On 11/03/22 at 12 30PM V2 Director of Nursing said, R377 was at risk of developing pressure wounds but did not have a history of any pressure related wounds prior to this one. There are no skin assessments available that depict the worsening of the sacral wound. There are no measurements documented after the wound was identified and I would have expected the nursing staff to communicate with the nurse practitioner or the primary doctor any progression of the wound. There was a time where the facility did	S9999		

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not have a Wound Care Coordinator, Nurse or provider due to staffing issues.

On 11/04/22 at 1:45PM V36 said, "I was alerted by the nursing staff that the rash on R377's sacrum was progressing after the blister ruptured. I was not following her prior to this because she didn't have any wounds. I usually expect for MASD to be resolved with barrier ointment, but for residents who are incontinent, it may take longer to heal because they are always sitting or lying in bed. I placed an order for honey and did the treatment and expected to round with the wound care doctor the following day. The next day, the wound care doctor identified the wound as unstageable because it contained some necrotic tissue with some slough and drainage. We debrided the wound to obtain a culture, and I placed orders for low air loss mattress and updated the treatment order. R377 did not have an air mattress in place at the time. We suspected that the wound may be infected based on how it presented. I abruptly ended my employment shortly after that and was not able to complete an investigation as to how the wound progressed.

On 11/04/22 at 12:56PM V37 Wound Care nurse said, I began working at the facility 9/19/22 and there was no wound care team in place. I came in and found that dressings and assessments were not being done and some residents didn't have wound orders or they weren't updated. The first time I was able to assess R377, she was in a lot of pain associated with the wound while I was providing care. I placed orders but decided that she needed to go to the hospital because the wound was beyond the level of care that we could provide in the facility. I asked the primary nurse at the time to contact Infectious Disease Nurse

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S9999	Continued From page 20 Practitioner and I told them that this wound was beyond our care. I felt that R377 needed quick antibiotics intravenously and a debridement because it was so bad. The wound care doctor wasn't expected to come for another week, and I didn't think we could wait that long. The wound was red, draining and necrotic. On 11/04/22 at 1:56PM V38 Nurse Practitioner (NP) said, I am the house NP and am in the facility 3 days a week. The nurses did not inform me of the sacral wound, and I did not review the progress notes from nursing or wound care that were in the chart. I did not discuss the sacral wound with the Infectious Disease Nurse either. R377's primary physician was not available to interview during this survey. V35 Medical Director interviewed on 11/03/22 at 3:35PM. V35 said, osteomyelitis is an infection of the bone that can spread to the bloodstream. This can be caused by a wound or a pressure sore and requires extensive IV antibiotics usually at a minimum of 6 weeks. If a wound is infected and has some necrotic tissue it requires debridement to discover what is underneath. Osteomyelitis is hard to miss without an x-ray to determine the diagnosis. For a resident with a sacral wound, osteomyelitis can be caused when bacteria is introduced such as episodes of incontinence. Facility policy titled Skin Care Prevention states in part; Dependent residents will be assessed during care for any changes in skin condition including redness, and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider. For residents who are bed or chair bound, provide a chair cushion and	S9999		

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S9999	Continued From page 21 pressure reducing mattress. Facility policy titled "Monitoring of wounds and documentation states in part; " General Monitoring Guidelines: With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the Pressure Ulcer/Pressure Injury) should be documented. At minimum, documentation shoild include the date observed and : Location and staging; size; exudate; pain; wound bed; and description of wound edges and surrounding tissue. If a wound shows no signs of healing after three weeks, a reevaluation of the treatment plan including determining whether to continue or modify the current interventions is done. If the decision is made to retain the current regimen, documentation of the rationale of continuing the current plan will occur. R377's progress notes reviewed, and it was noted that no admitting diagnosis was documented. Hospital records requested which were not received during the survey conclusion. Death Certificate dated 10/25/22 lists primary cause of death as Sacral Osteomyelitis. ///// 3. R39 is a 91-year-old male with a diagnoses history of Moderate Protein Calorie Malnutrition, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Hemiplegia and Hemiparesis (Partial Paralysis) due to Cerebral Infarction (Stroke), Need for Assistance with Personal Care, and Peripheral Vascular Disease who was readmitted to the facility 09/03/2022. On 10/31/22 at 12:31 Observed R39 in his bed sleeping in a gown with his lunch meal at	S9999		

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bedside.

On 11/01/22 at 11:21 AM V22 (Agency Certified Nursing Assistant - CNA) reported R39 stated his but hurt when she informed him she was going to get him up out of bed. V22 stated she was going to give R39 a shower, but staff advised her not to because of his wound. V22 stated she was told by the nurses and CNA's not to get the residents dressed and out of bed. V22 stated a staff reported to her she had never seen R39 in clothes and never seen him up. V22 stated R39's bottom was raw and red. V22 stated multiple residents beds are worn out and sunken in and that's why they have wounds. Observed R39's mattress was tattered and sunken in the middle. Observed R39's mattress was not a pressure relieving mattress. V22 stated when she began providing care to R39 she observed him to be in a gown with a large amount of dried feces which means he was likely in that condition for a long time. Observed R39's removed gown with a large amount of dried feces on it.

On 11/01/22 at 11:58 AM Observed R39 sitting in his wheel chair in his room. R39 stated he has wounds on his butt and legs and they hurt. No offloading booties observed on feet.

On 11/02/2022 at 1:36 PM R39 lying in his bed. R39 wearing socks on both feet with no off-loading items on him or in his bed. During this time, V23 remove (Wound Nurse) R39's socks to reveal a dime sized wound on his left heel. V23 (Wound Nurse) was presented at the time.

V23 reported R39 has a foam dressing for his left heel wound. V23 also reported, R39's left heel wound is from pressure, and he should have heel protectors. R39's heel wound is open, draining

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S9999	Continued From page 23 and reaches past the first skin layer. V23 stated R39's heel is treated three times per week. Surveyor observed V23 applied barrier cream to R39's buttock wound without cleaning the area. V7 (Wound Nurse/Licensed Practical Nurse) stated R39's left heel wound is a vascular wound. V7 reported the following: R39's wound was noted in his medical records as a diabetic wound and possibly he has diabetes. V7 stated a pressure wound would be open. She would label R39's heel wound as unstageable due to not being able to fully observe the depth of the wound and having slough on the surface. V7 stated R39's heel wound should be treated with med honey and she will update his treatments and have the physician update the stage of his wound. V7 stated the wound physician was aware of his heel wound and he is on a list to be seen tomorrow. R39 has had a stage 3 wound to his left and right buttocks which he has had for a couple of weeks. V7 believes those wounds have resolved and the treatments for that area should be changed to a barrier cream. V7 stated R39 does not have a pressure relieving mattress. She believes R39 has developed a fungal rash around his buttock area due to moisture and it requires barrier cream. Observed R39's buttock area to with red, scaly, irritated skin. V7 stated R39's buttock wound was not as red when she last observed it during treatment. V7 stated R39's sunken mattress wound hinder his wound from healing because the cushion is compromised and no longer providing protection for his skin. V7 stated R39 needs a new mattress or a pressure relieving mattress. V7 stated she began working for the facility 10/10/22, went on vacation 10/17/22 and returned from vacation on 10/24/22 during which time she began working as the wound coordinator. V7 stated she oriented with	S9999		

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S9999	Continued From page 24 the previous wound coordinator for a few days before going on vacation then when she returned began providing wound care on her own. R39's current care plan documents he has MASD (Moisture Associated Skin Damage) to sacral area; diabetic left heel wound. R39 has potential for further skin impairment related to Disease processes of Immobility and history of pressure injuries with interventions including: Anticipate and meet the resident's, care and safety needs. Be sure the resident's, call light is within reach and encourage to use it for assistance as needed. R39 has, an ADL (Activities of Daily Living) Self Care Performance Deficit related to diagnoses history of Anxiety, Type 2 diabetes mellitus, Glaucoma, cerebral infarction and requires an extensive assist of one staff member for bed mobility, toileting and transfers. R39's current physician order sheet documents an active order effective 09/28/2022 for a pressure reduction mattress, reposition every 2 hours, offload heels. R39's wound care progress notes dated 9/4/2022 documents: R39 is noted as 91 year old male admitted with a diagnoses history of Type 2 Diabetes Mellitus, Congestive Heart Failure, and Nonrheumatic Aortic Stenosis; patient noted with skin warm, dry with stage 3 wound to Left Buttock and Right Buttock, skin tear to Left Posterior Thigh and diabetic ulcer to Left Heel with slough tissue present; patient noted with risk for further skin integrity conditions due to sensory deficit, limited mobility and decreased cognition; preventative skin integrity measures initiated upon admission, air loss mattress ordered at this time.	S9999		

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S9999	Continued From page 25 R39's initial wound evaluation report dated 09/08/2022 documents he was examined with newly developed one day old stage 3 pressure wounds of the left and right buttocks with interventions including: house barrier cream every shift for 30 days, off load wound, Low air loss mattress, Turn side to side and front to back in bed every 1-2 hours if able; newly developed one day old diabetic left heel wound with interventions including: medicated honey apply three times per week for 30 days, Gauze dressing applied three times per week for 30 days, Float heels in bed; Off-load wound; Sponge boot. R39's wound care progress note dated 11/2/2022 3:24PM documents resident was assessed by wound team. Wounds to left and right buttock noted resolved no open area noted, but buttocks noted with bright red redness with white patches (Fungal) orders updated. Resident may have an air loss mattress, Heel boots worn while in bed. 4. R228 is a 90-year-old male with a diagnoses history of Unstageable Pressure Wound of Sacral Region, Difficulty in Walking, and Weakness who was originally admitted to the facility 10/09/2022. On 10/31/22 at 12:50 PM Observed R228 in a gown in his bed receiving feeding assistance by V28 (Certified Nursing Assistant). On 11/01/22 at 11:21 AM V22 (Agency Certified Nursing Assistant - CNA) reported that she observed R229's adult brief to be heavily soiled while providing incontinence care to him earlier and she couldn't place a new brief on him because of the condition of his wound. V22 stated R228's wound was in such poor condition that the wound nurse expressed frustration with the	S9999		

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condition of his wound.

On 11/02/2022 from 1:11 PM - 1:30 PM V7 (Wound Nurse/Licensed Practical Nurse) stated R228 receives wound care on Tuesdays, Thursdays, and Saturdays. R228 has an unstageable sacral (between his lower back and tailbone area) wound. V7 stated R228's sacral wound has 50% dead tissue slough which is a result of pressure. The frequency of the med honey treatment helps to eat away the dead tissue. V7 stated R228's wound bandaging was last changed yesterday. V7 stated R228's wound is treated with med honey and foam during scheduled treatments and as needed. V7 stated R228's back condition appears to be a rash. V7 stated R228's back should be treated with barrier cream and moisturizer during daily care.

V23 (Wound Nurse) stated R228 appears to have moisture associated yeast around his groin area and if left untreated the skin will break down. At the time of the interviews, the surveyor observed R228's sacral area to be raw and show deep skin injury and a large area of reddened skin on his back. During the wound treatment, R228 yelled loudly in pain when being repositioned for skin assessment and when treatment was applied by V23 to his sacral wound. V23 applied cream to R228's groin area without cleaning the area. V23 stated R228's current care plan documents he requires assist with daily care needs related to chronic kidney disease, Pressure ulcer of sacral region unstageable hypertension, afibrillation, Obstructive sleep apnea, pulmonary fibrosis, retention of urine, low back pain. Resident is a total assist of two staff members for transfers and toileting. Resident is an extensive assist of two staff members for bed mobility; with interventions including: Encourage/ Assist with turning and

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repositioning every two hours and as needed.

R228's current physician order sheet documents an active order effective 10/10/2022 for Reposition every two hours.

R228's point of care bed mobility reports from 10/23/2022 to 11/02/2022 document he was provided extensive assistance once on multiple days and twice on multiple days; once on 10/31/2022 and once in the morning and night shift on 11/01/22 and 11/02/22.

R228's point of care bed bowel incontinence reports from 10/23/2022 to 11/02/2022 document he was checked for bowel incontinence once during the afternoon on 10/31/2022 at 2:59PM and once 11/01/22 at 6:41AM and once during the night at 9:45PM.

On 11/04/2022 from 3:25PM - 3:40PM V2 (Director of Nursing) stated it is not documented in the medical records if residents are repositioned. V2 stated resident's incontinence status should be checked and changed every 2 hours and as needed and incontinence checks and changes are documented in the residents medical records. V2 stated the only way to confirm that a resident is being repositioned every 2 hours would be for it to be observed and monitored by the Certified Nursing Assistants and the Nurses. V2 stated the only way for administrative staff to monitor if residents are being repositioned every 2 hours would be to observe them repositioned. V2 stated she is not conducting rounds every 2 hours to monitor whether residents are being repositioned every 2 hours. V2 stated if R228's wound has worsened since it was developed, and the wound nurse indicated pressure as a contributing factor to the

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wounds current condition, it could potentially be due to not being turned and repositioned every 2 hours. V2 stated wound areas should be cleaned prior to applying barrier cream and if this is not being done there is a risk of holding moisture or irritation to the skin. V2 stated if R39 had an order for foam boots and pressure relieving mattress it should have been provided for him. V2 stated not having these interventions in place could cause R39's heel wound to worsen and his sacral wound to redevelop.

(A)

Statement of Licensure Violations (3 of 3):

300.610a)
300.1210b)2)
300.1210c)
300.1210d)2)
300.1220b)3)

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.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care

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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 care needs of the resident.

Restorative measures shall include, at a minimum, the following procedures:

2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

Section 300.1220 Supervision of Nursing Services

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Continued From page 30

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to prevent further decline of a contracture on bilateral hands for one (R78) of one resident reviewed for restorative program. This deficiency resulted in R78's range of motion on left wrist deteriorated from normal to moderate loss/50% of norm and on the right hand from normal to mild loss/75% of norm.

Findings include:

R78 is a 78 year old female, admitted in the facility on 02/12/22 with diagnoses of Primary Generalized (Osteo) Arthritis; Muscle Weakness, Generalized and Weakness.

On 10/31/22 at 11:30 AM, R78 was observed in bed, alert and verbal. Her hands are both

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S9999	Continued From page 31 contracted, fist like position, fingers were curled inward and tight. R78 stated she cannot move her hands. There was no splint, or any devices applied on both hands. On 10/31/22 at 2:59 PM, V21 (Family Member) was visiting R78. V21 verbalized that he is concerned about R78's hands. He (V21) further stated that she (R78) used to wear a splint on both hands, but it was not applied anymore. On 11/01/22 at 12:47 PM, R78 was observed asleep on bed. No splints observed on both hands. On 11/01/22 at 12:50 PM, V15 (Restorative Nurse) was asked regarding R78"s splint. V15 stated, "She is on restorative nursing. She wears splint during the day and into the night." V16 (Restorative Aide) was also asked on 11/01/22 at 12:53 PM if R78 needs to wear a splint on both hands. V16 replied, "She has a splint that she wears every day to prevent hands from contracting further." Facility's Nursing Rehab Standard Task documentation dated 05/18/22 for R78 documented: Standard Task: Nursing Rehab - Assistance with splint or brace Description: Assistance with bilateral splints. Should be applied during the day into the night. V15 was asked on when was the last time R78's splint was applied. V15 stated, "She is on the program for a splint, it is in the rehab plan of care but it was not scheduled. That is why it is not in the system. She was not wearing it probably because the Aide (V16) did not see it in POC	S9999		

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(point of care). V16 is a new Aide, been here for two and a half months. The treatment for wearing the splint did not pop up in the POC task. She does not have any logs to be signed when splint is applied. When I put it in POC, I did not put the shift that is why it did not populate."

There were no documentation or logs on R78's medical records regarding application of bilateral splints.

There was no care plan for restorative related to R78's bilateral splints application prior to 11/01/22.

V15 was asked on 11/02/22 at 1:16 PM regarding R78's care plan for splint. V15 stated, "I formulated the care plan for splint only yesterday, but OT referral is for her to wear splints. I guess, I oversight it. I did not do a care plan for the bilateral splints."

A care plan for R78, dated 11/01/22 documented: Splint: Requires the use of bilateral splints to her hands related to contractures. (R78) doesn't like to wear her splints that often due to her stating they cause her pain.
Interventions:
Encourage resident (R78) to assist with applying and removing brace. encourage resident to demonstrate ability to apply the brace and praise participation with program and improvements. Observe skin for complications related to brace usage every shift and each time it is removed. Provide proper cleaning of brace on residents" (R78) specific shower days and PRN (when necessary) when soiled. Provide verbal cues as to proper placement of brace when applying. Splint to be on during the AM (morning) and off at PM (evening) up to eight hours as tolerated.

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S9999	Continued From page 33 On 11/02/22 at 10:54 AM, V14 (Director of Rehab, Long-Term Care) was asked regarding R78. V14 replied, "She was evaluated for OT on 08/02/22 for three times a week for four weeks. The goal is for her to wear her splint bilaterally for two hours every day. Her hands are both contracted, in fist position, tight and painful for her when fingers are straightened out. During therapy, she improved from not wearing the splint to wearing it for two hours as tolerated. She was discharged from OT on 08/29/22, she met his goals for wearing the splint and able to perform other set goal tasks. She was referred to Restorative Nursing to continue wearing the splint." R78's OT DC summary 08/29/22: Summary since eval (evaluation)/SOC (start of care): Patient response - patient has reached maximum potential with skilled services; Discharge status and recommendations: Restorative Nursing Program On 11/03/22 at 1:15 PM, V2 (Director of Nursing) was interviewed regarding R78 and splint application. V2 stated, "Splints should be applied according to doctor's orders. For R78, there should be an order obtained for her splint at the time that splint was recommended. I am not sure what happened. Restorative Department is the one responsible for the orders and the application of splints or braces. R78's OT evaluation dated 11/03/22 documented in part: Range of Motion (ROM) Goniometric Measurements: Joints - Shoulder = impaired; Elbow/Forearm = impaired; Wrist = impaired; Shoulder = impaired;	S9999		

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Elbow/Forearm = impaired; Wrist = impaired

R78's Range of Joint Motion Screen dated 09/28/22 documented:
A. Evaluation
6. Left wrist and fingers (flexion and extension)
   1. Within normal limits
7. Right wrist and fingers (flexion and extension)
   1. Within normal limits

R78's Range of Joint Motion Screen dated 11/02/22 documented:
A. Evaluation
6. Left wrist and fingers (flexion and extension)
   3. Moderate loss/50% of norm.
7. Right wrist and fingers (flexion and extension)
   2. Mild loss/75% of norm.

On 11/03/22 at 1:54 PM, V34 (Physician) was interviewed regarding R78 and use of splint. V34 stated, "She is a long-term patient. Been taking care of her for five to six months now. She had history of stroke before, has contracture on both hands due to inability to move them. Use of splints can help in preventing further decline in contractures."

Facility's policy titled, "Splints" review date 10/2021 stated in part but not limited to the following:
Guideline:
1. Residents will be evaluated for the use of a splint based on their assessed deformity or contracture.
2. A physician's order will be obtained for any needed splint.

(B)