STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009799	A. BUILDING: _____ B. WING _____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF WAUKEGAN	2217 WASHINGTON STREET WAUKEGAN, IL 60085

(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 Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 identify and assess prior to developing unstageable and stage 3 pressure injuries. These failures resulted in R49 developing multiple unstageable pressure injuries. The failure also resulted in R49 developing a MRSA infection in his sacral wound. This applies to 2 of 5 residents (R49 & R58) reviewed for pressure injuries in the sample of 18. The findings include: 1. R49's face sheet lists his diagnoses to include: paraplegia, muscle weakness, abnormal posture,	S9999		

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S9999	Continued From page 2 sepsis, methicillin resistant staphylococcus aureus infection, type 2 diabetes mellitus, neurogenic bowel, and neuromuscular dysfunction of bladder. R49's face sheet shows, he was admitted to the facility on June 2, 2022. R49's skin observation tool dated June 2, 2022 on admission shows, he had a stage two pressure injury to his coccyx. There were no other pressure injuries documented on the initial skin assessment. R49's skin impairment/wound form dated June 8, 2022 (6 days after admission) shows, "Initial Findings: stage 4 pressure injury: full thickness skin and tissue loss to sacrum. Measurement of wound (Length X Width X Depth): 7.5 cm (centimeter) X 7.5 cm X 2.0 cm. 50% slough, 25% eschar (dead tissue), Other: exposed tissue: muscle. Moderate serosanguineous drainage. Additional wound: Stage 4 pressure injury: full thickness skin and tissue loss to left heel. Measurement of wound: 1.0 cm X 1.0 cm X 0.1 cm. R49's wound physician progress notes dated June 8, 2022 shows, "Wound 1: pressure to sacral stage 4 date reported June 8, 2022, Wound 2: pressure to left heel unstageable date reported June 8, 2022. R49 was only admitted with a stage 2 pressure injury to coccyx/sacrum. R49's census report shows, he was sent to the hospital on July 6, 2022 and re-admitted to the facility on July 11, 2022.	S9999		

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S9999	Continued From page 3 R49's skin observation tool on re-admission dated July 11, 2022 shows, "Description: stage 4 coccyx, fresh dressing present, redness to buttocks, back thighs, areas to bilateral heels. Specialty equipment is in place as ordered? none ordered. What equipment is ordered: not applicable." There is no assessment of R49's wounds. R49's skin impairment/wound form dated July 13, 2022 (2 days after re-admission) shows, "deep tissue pressure injury" persistent non-blanchable deep red, maroon or purple discoloration to right ischial." R49's physician progress notes dated July 13, 2022 (2 days after re-admission) shows, "Wound 1: pressure sacral stage 4. Measurements: 15 cm X 17.5 cm X 2 cm. 60% granulation, 20% necrotic/eschar and color, 20% slough and color. Wound 2: pressure left heel unstageable. Measurements: 4 cm X 3.5 cm X 0.1 cm. 40% granulation, 50% black necrotic/eschar and color. Wound 3: pressure right ischial deep tissue injury. Date reported: July 13, 2022." R49's census report shows, he was sent to the hospital on July 23, 2022 and returned to the facility on July 27, 2022. R49's skin observation tool on re-admission dated July 27, 2022 shows, "Stage 4 coccyx, slight bruising to bilateral arms, areas to bilateral heels." There is no other documentation or assessments of wounds on re-admission. R49's progress notes dated July 28, 2022 shows, "resident readmitted back to the facility with unstageable pressure injuries to left heel, to right back, and coccyx. Treatment orders in place..."	S9999		

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S9999	Continued From page 4 Another progress note on the same date shows, "pressure injury to right buttock has changed from DTI to unstageable, and new pressure injury to right back unstageable post hospitalization." There are no assessments on re-admission on July 28, 2022. R49's census report shows, he was sent to the hospital on July 31, 2022 and returned to the facility on August 9, 2022. R49's skin observation tool dated August 2, 2022 (while he was in the hospital) shows, "left heel, unstageable, sacrum, treatment in progress. See progress notes, other right ischial and right back." R49's re-admission data collection tool dated August 9, 2022 shows, "Skin Condition: right buttock- open wound, left buttock- open wound, right thigh-redness, left thigh-redness, right heel-black discoloration, left heel-black discoloration, left gluteal fold-open wound, right gluteal fold- open wound." The right heel that was first documented by the facility on July 11, 2022 is now an unstageable upon re-admission. There are no assessments of right heel when first discovered on July 11, 2022. There is nothing documented about the right back unstageable wound. There are no assessments of any wound on re-admission. R49's physician progress notes dated August 10, 2022 shows, "Wound 1: pressure sacral stage 4, 15 cm X 16 cm X 2 cm, 60% granulation, 20% necrotic/eschar color, 20% slough and color. Wound 2: pressure left heel unstageable. 6 cm X 4.5 cm X 0.1 cm, 100% necrotic/eschar color, Wound 4: pressure right ischial stage 3, 4.5 cm X 3 cm X 0.2 cm 50% granulation, 30% slough. Wound 5: pressure right heel unstageable, 3 cm	S9999		

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S9999	Continued From page 5 X 3.5 cm X 0 cm, 100% necrotic/eschar color. Wound 6: pressure left ischial stage 2, 3 cm X 2 cm X 0.1 cm. Wound 7: pressure low right back unstageable, 7 cm X 5 cm X 0.2 cm, 50 % yellow/ necrotic/eschar color." R49's census report shows he was sent to the hospital on September 5, 2022 and re-admitted on September 9, 2022. R49's re-admissions data collection tool dated September 9, 2022, shows nothing for skin conditions. There are no assessments documented. R49's physician progress notes dated September 14, 2022 (5 days after re-admission) show "pressure sacral stage 4, pressure left heel unstageable, right ischial unstageable, pressure right heel unstageable, pressure right lower back unstageable." R49's skin impairment/wound form dated October 11, 2022, shows "Initial findings: left lateral leg unstageable pressure injury: obscured full-thickness skin and tissue loss. 4 cm X 4 cm X 0 cm. 80% eschar. Additional wound: right lateral leg unstageable pressure injury: obscured full-thickness skin and tissue loss. 5 cm X 5 cm. 80% eschar. R49's progress notes dated October 11, 2022, shows "Resident has unstageable pressure injuries to left and right leg due to heel protectors. Heel protectors removed and treatment in place. Will use pillows to offload heels." R49's census report shows he was sent to the hospital on October 11, 2022 and re-admitted to the facility on October 18, 2022.	S9999		

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S9999	Continued From page 6 R49's re-admission data collection tool dated October 18, 2022, shows nothing for skin conditions. There are no assessments documented. R49's progress notes dated October 21, 2022 (3 days after re-admission), shows "skin check post hospital stay. Resident seen by wound care NP. See progress notes... Pressure injures to sacrum, left heel, right ischial, right heel, right lower back, left lateral leg, and right lateral leg. Resident currently on isolation for MRSA in the wound. Has ongoing IV (intravenous) antibiotic therapy..." On October 24, 2022 at 11:13 AM, R42 was lying in bed on his back. He had gray boots on his feet that went up to just below his knee. He was on contact isolation for MRSA in his sacral wound (infection). At 11:45 AM, V13 (R42's wife) stated he has two new pressure injuries to his lateral legs because the boots caused friction. He is not supposed to be wearing those boots anymore. (He was wearing the boots that caused the friction/wound to his lateral legs). On October 26, 2022 at 9:09 AM, R42 was lying in bed. V4 (Wound Care Nurse) was changing the dressings on his wounds. His right lateral back had a large tennis ball-size open wound. There was yellow and pink tissue inside of the wound. The area around the wound was red. He had a grapefruit-sized open area to his sacral area. There was yellow and black tissue inside the wound. The area around the wound was red. His right ischial had approximately half-dollar-sized open area with yellow tissue inside the wound. The area around the wound was red. His right lateral leg had two wounds that	S9999		

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S9999	Continued From page 7 were black in color. One was the size of a dime but elongated. The second was smaller than a dime and elongated. The left lateral leg had a dime-sized wound that was black in color. Both heels were a little bigger than a half dollar in size. Both had a large amount of bloody drainage. They were red and bloody in color. On October 25, 2022 at 3:17 PM, V4 (Wound Care Nurse) stated, if she wasn't here when R49 was re-admitted then there are no assessments until she came back to work. The nurses are able to do the assessments but didn't do them. R49 developed his lateral leg wounds from the boots he was wearing because they were rubbing on his skin. He is high risk for pressure injuries. R49's minimum data set dated September 16, 2022, shows he is cognitively intact and requires extensive assist of one person for bed mobility, total dependence of two people for transfers, and total dependence of one person for toilet use. R49's care plan initiated on June 7, 2022 (admission date was June 2, 2022) shows, "Focus: The resident was admitted with a stage 4 to sacrum, unstageable to left heel, unstageable right ischial, unstageable right heel, and stage 4 to right low back (initial admission assessments show he was only admitted with a stage 2 on his sacrum. Skin observations show left heel, right low back, right lateral leg, left lateral leg and right ischium developed in the facility) related to impaired mobility, weakness, friction, and shear. Interventions: Antibiotic for MRSA (date initiated July 23, 2022), assess, record, monitor wound healing every shift. Report improvements and declines to the MD (medical doctor), monitor/document/report PRN (when needed) any changes in skin status: appearance, color,	S9999		

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wound healing, signs/symptoms of infection, wound size (length X width X depth), stage (date initiated June 7, 2022)."
R49's care plan initiated on June 2, 2022 shows, "Focus: The resident has potential for impairment to skin integrity. Co-morbid conditions, presence of colostomy, impaired mobility/strength. Interventions: follow facility protocols for treatment of injury."

The facility's pressure ulcer prevention effective date November 28, 2012, shows, "Purpose: To prevent and treat pressure injury (s). If a PU/PI (pressure ulcer/pressure injury) is present, the facility will provide treatment and services to prevent infections and development of additional PU/PUs... Guidelines: 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures."

The facility's management of wounds (no date) shows, "Policy: Our mission is to facilitate resident independence, promote resident comfort, and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective wound management program, allowing our residents a means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. 1. Assessing the resident: Since the assessment is the beginning of any wound management program, it is the policy of this facility to assess the entire person, not just the wound. It is on this assessment that the plan of treatment will be based. This assessment will begin at the time of admission and will continue throughout the resident stay. It will include the resident physical health, common risk factors, nutritional status, and wound pain level. This assessment will be done using the following

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policies: Pressure injury risk assessment: to be done on all residents on admission, weekly for the first four weeks, then quarterly and with change in cognition or functional ability using a valid pressure ulcer risk assessment tool. Skin assessments: to be done according to the skin assessment protocol schedule. Nutritional and hydration screening: to be done on admission, quarterly, with a significant change, for any resident with a current wound or Braden less than 12, and when wound stalling has occurred. 2. Assessing the local wound condition: It is the policy of this facility to use a uniform wound assessment that will provide a consistent means of wound evaluation. This assessment will facilitate continuity of care and communication among staff. This documentation will be completed using the following: Wound assessment policy and procedure."

2. R58's face sheet shows she is a 65-year old female with diagnoses including contractures to the right and left hand, contracture to right knee, stage 4 sacral pressure ulcer, dysphonia and history of falling.

R58's Minimum Data Set assessment dated 9/29/22 shows she has moderately impaired cognitive deficits, no rejection of cares, and is total dependent on staff with two persons assist with bed mobility and transfers.

R58's Skin Braden Scale assessment dated 10/21/22 shows she is a high risk for developing pressure sores.

On 10/24/22 at 9:39 AM, R58 was lying in her bed. V4 (Wound Care Nurse) assisted R58 on to her side, a foam dressing was in place to her right

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S9999	Continued From page 10 upper shoulder, and a foam dressing in place to her sacrum. V4 said R58 has an acquired stage 3 pressure ulcer to her right shoulder. On 10/24/22 at 2:02 PM, V4 said R58 is total dependent on staff for care, repositioning, and a high risk for developing pressure ulcers. In March 2022, she developed a stage 3 pressure ulcer to her right shoulder blade area from the friction of the wedge cushion against her skin. V4 said they are now using a soft pillow for positioning. R58's wound progress notes dated 10/19/22 documents a stage 3 pressure ulcer to the right upper back measuring 5 cm (centimeters) x 6.5 cm x 0.9cm. R58's wound progress note dated 3/16/22 documents a new acquired stage 3 pressure ulcer to the right shoulder measuring 1.2 cm x 1 cm x 0.1 cm. The same note showed to avoid bony prominences under direct pressure. The facility's Pressure Ulcer Prevention Policy revised 8/2022 states, "To prevent and treat pressure injury (s). If a pressure ulcer/pressure injury is present, the facility will provide treatment and services to prevent infections and development of additional pressure ulcers/pressure injures. A Braden assessment will be completed upon admission, weekly and first four weeks after admission...inspect skin daily, turn dependent residents approximately every two hours, or as needed and position with pillow or pads protecting bony prominences..." (A)	S9999		