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	IL6010094	A. BUILDING: _____ B. WING _____	10/27/2022

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WINNING WHEELS	701 EAST 3RD STREET PROPHETSTOWN, IL 61277

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S 000	Initial Comments Annual Licensure and 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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 requiremnts are not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure interventions were in place for a resident at risk for pressure ulcers, failed to identify pressure ulcers prior to becoming advanced stages, and failed to complete weekly assessments of pressure ulcers for 4 of 7 residents (R30, R19, R26, and R80) reviewed for pressure ulcers in the sample of 18. These failures resulted in R30 developing two pressure ulcers identified at a stage 2 and an unstageable, R19 developing a pressure ulcer identified at unstageable, and R26 developing 2 pressure ulcers identified at Stage 3 and unstageable. The findings include: 1. R30's face sheet showed he was admitted to the facility on 4/13/2016 with diagnoses to include	S9999		

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quadriplegia, neuralgia and neuritis, hallucinations, suicidal ideations, history of urinary tract infections, traumatic brain injury, and cardiac arrhythmia. R30's facility assessment dated 9/12/22 showed he has moderate cognitive impairment and requires extensive physical assistance of 2 staff for bed mobility, dressing, and toilet use and is completely dependent for transfers. R30's assessment for predicting pressure ulcer risk dated 9/22/22 showed R30 to be at high risk.

R30's 10/25/22 entered at 12:09 PM, Skin/Wound Note entered by V4 Wound Care Nurse showed, "New area to left knee at bend observed. Measures 1.0 cm x 1.0 cm granulating tissue. Edges attached. Cleansed and dry dressing applied. Appears catheter tubing to have been caught in bend of leg. Pressure area to lateral aspect of right foot 5th digit measures 0.5 cm x 1.0 cm x 0.0 cm. Hard/firmly attached. Denies pain. Resident educated on not wearing shoes at this time. Air mattress in place ..." On 10/26/22 the area to the 5th digit of the right foot was observed with a scab over the injury making the area "unstageable".

R30's care plan initiated on 9/3/22 showed, "[R30] is at risk for impaired skin integrity and pressure ulcer injuries due to Spinal Cord Injury, Wounds, history of not following wound interventions, history of failed wound flaps, and history of wound infections. Resident has limited mobility, decreased strength, and incontinence of bowel... Interventions: ... Air mattress on bed for pressure relief. Ensure proper functioning for air mattress daily..."

R30's care plan initiated on 10/25/22 showed, "Documented Pressure Ulcer. New area to left

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knee at bend observed. Measures 1.0 cm x 1.0 cm x 0.0 cm granulating tissue. Edges attached. Cleansed and dry dressing applied. Appears catheter tubing to have been caught in bend of leg... Interventions: ... Notice to staff to ensure catheter tubing is in correct position..."

R30's care plan initiated 10/25/22 showed, "Documented Pressure Ulcer. Pressure area to lateral aspect of right foot 5th digit measures 0.5 cm 1.0 cm x 0.0 cm. Hard/firmly attached. Denies pain. Resident educated on not wearing shoes at this time. Resident has had an increase in swelling to bilateral lower extremities... Interventions: ... Educated resident on the importance of not wearing shoes until wound has healed..."

R30's care plan initiated 10/19/22 showed, "Documented Pressure Ulcer DTPI (Deep Tissue Pressure Injury) to right heel measures 1.0 cm x 1.5 cm. Admitted with this from the hospital..."

R30's Skin Only Evaluation dated 10/25/22 showed, "...Skin Issue: Pressure Ulcer/Injury. Skin Issue Location: knee bend, Pressure Ulcer/Injury Stage 2... New area to left knee at bend observed. Measures 1.0 cm x 1.0 cm x 0.0 cm granulating tissue.. Appears catheter tubing to have been caught in bend of leg. Pressure area to lateral aspect of right foot 5th digit... Resident educated on not wearing shoes at this time. Air mattress in place..."

R30's complete care plan was reviewed and showed no updates regarding R30 not being able to wear shoes.

On 10/25/22 at 1:30 PM, R30 was in his room sitting in his motorized wheelchair. R30 was

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S9999	Continued From page 4 wearing white tennis shoes. On 10/26/22 at 9:39 AM, V4 LPN-WCN (Licensed Practical Nurse-Wound Care Nurse) and V13 CNA (Certified Nursing Assistant) were providing wound care for R30. R30's air mattress control box was on the footboard of his bed. The air mattress power button was in the "off" position. V4 was providing wound care to R30's right foot, 5th toe. V4 said she found this pressure area yesterday. V4 said R30 should have cushioned heel boots on when in his chair, V4 then said R30 should have heel boots on at all times. The surveyor asked V4 if the mattress on R30's bed is an air mattress. V4 responded, "It is a pressure reduction mattress, it does basically the same but the air doesn't go thru the coils like a low air loss mattress does." On 10/26/22 at 1:51 PM, R30 was observed in his motorized wheelchair in the main hallway. R30 was wearing his tennis shoes. On 10/27/22 at 11:15 AM, V13 CNA said, "We rotate [R30] on his sides when in bed and in his chair he has the option to adjust the chair to prevent pressure. It's ok for him to wear shoes. I haven't been told he can't. He doesn't have an air mattress." On 10/27/22 11:10 AM, R30 was laying in his bed. The air mattress control box on the footboard of his bed was in the "off" position. R30 said he doesn't think he has an air mattress on his bed. R30 then said, "I don't have a bed that the air goes in and out of if that is what you mean. I can wear shoes. No one has ever told me that I shouldn't wear shoes. They never said anything like that to me. If they told me I had sores on my feet, I would be ok with not wearing shoes while	S9999		

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S9999	Continued From page 5 they heal." On 10/27/22 at 12:53 PM, V4 WCN said, "R30 has the air mattress for pressure prevention. It is a pressure relieving mattress, but not the coil one. The pressure ulcer to his 5th digit of his right foot I just found the other day. It was quite possibly caused by his shoes that he has still been wearing. He isn't supposed to be wearing shoes since he came back from the hospital. I put the shoes on hold and he is supposed to be "boots only". The CNAs know he isn't supposed to wear shoes. I found the one behind his knee on Monday the same time as I found the one on his 5th digit. The cause of the knee one was easy to figure out, when I found it, his catheter tubing was ran behind his knee and was still there. I educated the CNAs on them watching the placement of his catheter tubing." 2. R19's face sheet showed he was admitted to the facility on 9/17/2001 with diagnoses to include intracranial injury with loss of consciousness of unspecified duration, Type 2 Diabetes, Mild Intermittent Asthma, dysphagia, major depressive disorder, obstructive and reflux uropathy, anemia, nutritional deficiency, essential hypertension, and venous insufficiency. R19's facility assessment dated 8/17/22 showed he is cognitively intact and requires the extensive physical assistance of 2 staff for bed mobility, dressing, and toilet use. R19's care plan initiated on 8/29/22 showed, "Documented Pressure Ulcer, Deep Tissue Pressure Injury, Unstageable, 5.1 cm x 3.8 cm soft, dark purple area inside of a 8.0 cm x 9.1 cm lightly discolored area to his left heel. R19's 8/30/22 Skin/Wound Note showed, "Resident seen by wound nurse for pressure area	S9999		

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S9999	Continued From page 6 to left heel..." On 10/27/22 at 1:02 PM, V4 LPN/WCN said, [R19] gets a pressure injury on his heel whenever he wears his shoes, so then we put his shoes on hold. They heal pretty quickly, always start as a blister. For prevention he wears heel boots in bed at all times and he has frequent skin checks. I think his skin checks are weekly. I frequently go in and check him in between skin checks too. The CNAS look over the skin and are supposed to notify the nurses on a shower sheet for any changes to the skin. The nurses have their scheduled skin checks too. So I would expect a wound to be identified at a stage 1. It should be noticed and reported the minute they find it red." 3. R26's face sheet showed he was admitted to the facility on 8/7/2018 with diagnoses to include quadriplegia, dislocation of C6/C7 cervical vertebrae, idiopathia hypotension, disorder of pancreatic internal secretion, edema, hypotension, autonomic neuropathy, and fusion of cervical spine. R26's facility assessment dated 8/30/22 showed he has no cognitive impairment and requires extensive assistance of 2 staff members for all cares. R26's care plan initiated on 4/20/20 showed, "Risk for Impaired Skin Integrity and a high risk for pressure ulcers per assessment. Resident requires total assist for transfers, TBI (Traumatic Brain Injury) quadriplegia... Residents BLE (Bilateral Lower Extremities) fluctuate with edema at times causing skin issues..." R26's care plan initiated on 9/9/22 showed, "Documented Pressure Ulcer-Stage 2 dark fluid filled blister to plantar aspect of left foot. Measures 2.0 cm x 2.5 cm, light drainage from	S9999		

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S9999	Continued From page 7 lateral blister due to foot hitting the end of the headboard... Notify staff to ensure resident is up all the way in bed and reduce sliding in bed with knees and feet elevated..." R26's care plan initiated on 9/29/22 showed, "Documented Pressure Ulcer 2.3 cm x 3.0 cm, Stage 3 pressure area to left malleolus. Granulating tissue with moderate sanguineous drainage. Edges firmly attached. Resident unable to feel area... CNAs educated on positioning of leg..." R26's 9/9/22 Skin/Wound Note showed, "Resident reports dark fluid filled blister to plantar aspect of left foot. Measures 2.0 cm x 2.5 cm, light drainage from lateral blister. Resident often slides to foot of bed pressing feet against the footboard. Is unable to feel pressure. Blister cleansed and skin prep applied...." R26's 9/9/22 Skin Only Evaluation showed R26 to have a new stage 2 pressure injury to plantar area of his left foot. R26's Wound Physician note dated 9/13/22 showed, ".... Unstageable DTI (Deep Tissue Injury) of the left, plantar, lateral foot..." R26's 9/29/22 Skin/Wound Note showed, "New Pressure Ulcer: During rounds observed resident to have 2.3 cm x 3.0 cm, Stage 3 pressure area to left malleolus. Granulating tissue with moderate sanguineous drainage. Edges firmly attached. Resident unable to feel to area... LLE (Left Lower Extremity) floated on pillow to prevent pressure. CNAs educated on positioning of leg..." On 10/27/22 at 12:44 PM, V4 LPN/WCN said, "[R26] has pressure to his left malleolus and left plantar foot. He is so long that his mattress slides to the end of the bed so his foot ended up against the footboard. We have ordered a wedge that will	S9999		

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go between the mattress and the footboard to prevent the mattress from sliding down. He is extremely tall, I think he is over 6 feet and he is in our longest bed." V4 said she is the one that finds most of the new skin issues because she finds them when she is doing treatments. V4 said both the left malleolus and left plantar foot were identified by her while she was doing R36's other treatments because she has a habit of doing skin checks while she does treatments. V4 said the nurses on the floor do skin checks as well. V4 said prevention measure for R26 are wearing heel protectors and staff checking to make sure he is pulled up in bed frequently. V4 said the bed adjusts at the knees and feet which help to prevent sliding. V4 said R26 actually prefers to have his feet up.

The facility's policy titled Pressure Ulcer Prevention Program with revision date of 6/2014 showed, "It is the policy of this facility that upon admission, a licensed nurse assesses each resident for pressure area potential... The facility will ensure that a resident that enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. The facility will promote the prevention of pressure ulcer development; The facility will promote the healing of pressure ulcers that are present... The facility will prevent the development of additional pressure ulcers..."

The facility's policy titled Skin and Wound Care Program with revision date of 12/2015 showed, "Wound Management: An Interdisciplinary Approach/Wound Care Team... Due to the complexity of managing a resident with wounds, a coordinated approach to resident care is essential for promoting maximum resident outcomes. Each

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team member assesses the resident's needs and communicates this information so that treatment planning is interdisciplinary and holistic in nature. The interdisciplinary approach will increase staff awareness of the problem, heighten identification of ulcers at earlier stages, reduce the incidence of pressure ulcers in the health care setting and provide enhanced control measures by management..."

4. On 9/25/22, R80 was found to have a stage 1 pressure injury to her left outer heel measuring 1.7 cm by 1.9 cm. On 9/26/22, V4 noted a blister to the left heel fluid filled with a slow leak of serous drainage.

The 10/3/22 assessment shows the wound to measure 2.0 cm x 2.3 cm with necrotic tissue. No further assessments were completed for the wound until 10/26/22.

On 10/26/22, R80 was observed to have an open dime sized reddened wound on her left heel. R80 denied any pain and does not know exactly how she acquired the pressure injury, but believes it to be from her shoes.

On 10/26/22 at 8:10 AM, the wound had no drainage and was left open to air. V4 stated all wounds are measured and assessed weekly and documented in the progress notes.

On 10/27/22 at 8:17 AM, V4 stated she missed 2 weeks of measurements and assessments when she was out with Covid. She said the nurses should have been treating and ideally measuring and documenting.

On 10/27/22 at 12:08 PM, V2 DON (Director of Nursing) said (V4) is the wound nurse and

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S9999	Continued From page 10 performs the assessments and measurements. When she was not here, the floor nurses should have been doing the assessments and measurements. The facility's 12/2015 skin and wound care program documents Wound care coordinator: responsibilities 2. Documentation of the stage wound occurs weekly. 5. Completes the weekly pressure sore documentation using the weekly assessment forms provided by the facility. (B)	S9999		