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	IL6000046	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDOLORATA VILLA	555 MCHENRY ROAD WHEELING, IL 60090

(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 Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. 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. 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 are not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the plan of care	S9999		

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S9999	Continued From page 2 and procedures for wound prevention to heal a preventable facility-acquired pressure sore for 1 (R16) of 3 residents reviewed in the sample of 36 residents. In addition, the facility failed to provide effective pain management to a cognitively impaired resident and failed to identify signs and symptoms of pain for 1(R16) of 5 residents reviewed for pain in the sample of 36 residents. These failures resulted in R16 sustaining a facility-acquired, clinical stage 4 pressure ulcer to the sacral area and caused (R16) to endure pain during a wound care procedure. Findings include: R16 is a cognitively impaired 78 year old resident with diagnoses listed in part with hemiplegia and hemiparesis, gastrostomy, heart failure, and pressure ulcer of sacral region stage 4. A facility wound surveillance report provided to the survey team on 2/14/23 shows (R16) with a wound type described as Pressure, Subtype: Stage 4: Body location: Sacrum; Measurements: 2.7 centimeters length x 1.6 centimeters width x 0.3 centimeters depth; Acquired: IHA (In House Acquired)." Physician orders dated 5/24/2022 reads in part: "Turn and Reposition every two hours every shift for prevent pressure injury." On 2/14/23 at 10:40 AM, R16 was observed in bed asleep on her back with her torso raised up several inches and lying atop a blue-colored air mattress. There were numerous, white-colored sheets on the bed mattress and a tight fitted sheet appeared to wrap around the mattress compressing the sides of the air mattress. An air pump was dangling precariously with one hook at	S9999		

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S9999	Continued From page 3 the foot of the bed and had tubes that were hitting the ground. V7 (RN) was asked about R16 and stated, "Yes, she is my patient. She is always in bed. I have two Certified Nurse Assistants (CNA's) today but usually we have 3 on the floor." At 2:20 PM, R16 was observed in the same position on her back with her torso and head slightly raised up as was previously observed at 10:40 AM. On 2/15/23 at 9:20 AM, R16 was observed asleep in bed on her back with her torso raised up several inches. A tightly fitted sheet remained wrapped around R16's air mattress compressing the sides of the air mattress and there were again multiple layers of sheets on the mattress over and under R16's body. The same mattress pump remained dangling at the foot of the bed with one hook and tubing hitting the floor. On 2/15/23 at 11:10 AM, surveyor asked V7 (RN) to come and see R16 with the surveyor. R16 appeared to be in the same position and was observed in bed asleep on her back with her torso raised up several inches. Surveyor asked V7 to describe to the surveyor R16's positioning, V7 stated, "She is on her back, and we raise her head up a little bit for comfort." Surveyor asked to describe more about R16, V7 stated, "(R16) has a G-tube (gastrostomy tube) and a urinary catheter because she has a pressure ulcer on her sacral area. I don't know if she got the pressure ulcer here or from the hospital, but I think I was told it was from here. The wound nurse (V3) comes every Friday and they do wound rounds with her and the wound doctor, but I don't know anything else about it. The nurses do the wound care every day except Friday when V3 (wound nurse) does it. Wound care is done on the PM	S9999		

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shift mostly, so I don't normally do it because I am AM shift nurse." Surveyor asked how R16 appeared to her, V7 stated, "She looks uncomfortable, but she looks that way a lot. This is a fitted sheet, and it should not be here, we are supposed to have flat sheet." Surveyor asked why a fitted sheet was not supposed to be used as she said, V7 stated, "Because I think they told us it is not good for the air mattress to work." Surveyor asked about the green incontinence pads that were bunched up under R16's sacral area, V7 stated, "The CNAs shouldn't be using that much under her I will let the CNA know." Surveyor asked about the dangling mattress pump at the foot of the bed, V7 stated, "Oh, I saw that yesterday, I should have let maintenance know about it. I will call them now." Surveyor asked if the mattress pump was functioning properly, V7 stated, "I don't know. I don't touch this. I think it's working but I don't know anything about this." Surveyor asked if anyone instructed her on how to operate the mattress pump for R16, V7 stated, "No, maintenance takes care of this."

At 11:20 AM, V7 called in V8 (CNA) and asked her about R16's bed, V8 stated, "I didn't do her bed, that was the night shift that makes her bed." Surveyor asked how many incontinence pads were supposed to be under R16, V8 stated, "Those pads shouldn't be under her like that. It was probably when she was turned or something." Surveyor asked when she last turned R16, V8 stated, "I did it around 7:30 or 8, I don't remember." Surveyor asked if anyone helped her do this, V8 stated, "No, I did it myself and I was going to do it again just now that's why I came in."

MDS (minimum data set) dated 12/16/22 shows that R16 as rarely/never understood. Functional

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S9999	Continued From page 5 status of bed mobility as total dependence and requiring a minimum 2+ person to move from lying position, to turn side to side, and to position body while in bed. Section M on this same MDS assessment showed R16 with one stage 4 pressure ulcer and had 0 number of stage 4 pressure ulcers that were present upon admission/entry or reentry to the facility; Skin and ulcer/treatment interventions show R16 to have pressure reducing device for chair and bed but did not show that R16 was on a turning and repositioning program as ordered by the physician. On 2/15/23 at 2:40 PM, V15 (CNA) was observed in R16's room with the privacy curtain drawn. Surveyor entered the room, and V15 stated, "patient care!" to deter anyone from coming into the room. Surveyor came into the room, and V15 stated to surveyor, "Come here and help me change her." Surveyor identified self and informed V15 that surveyor was unable to comply with her request. Surveyor asked V15 what she was doing, V15 stated, "I was about to clean her (R16) up, should I stop?" Surveyor answered and said to continue how she normally took care of R16 and left the room." Physician orders dated 5/24/22 reads in part, "Pain assessment every shift for monitor pain record pain level and location: Acetaminophen: give 20.3 ml via G-tube every 6 hours as needed for mild pain related to chronic pain syndrome. " Review of records showed no physician orders to manage/mitigate pain before each wound treatment and most recent pain assessment conducted on 12/15/22 by V25 (RN) for R16. This pain assessment form shows "Frequency with which resident complains or shown evidence of	S9999		

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S9999	Continued From page 6 pain or possible pain, marked as "Not assessed." At 2:45 PM, Surveyor approached V14 (RN) and requested to see if he could observe him conduct wound care for R16, V14 stated, "Yes. I usually do her anyway on my shift." V14 proceeded to R16's room and saw V15 already in the room and informed her to clean R16 up because he was going to do wound care for R16. V15 was overheard saying, "I'm almost done so I will wait for you to do her dressing change." V14 went to his cart and took several supplies with him and placed them in his hand and brought them to the room and placed the supplies onto a bedside table and went into the bathroom to wash his hands and put on gloves. Surveyor asked V14 to explain the procedure to surveyor as he conducted the wound care. V14 stated, "(R16) is totally dependent and non-responsive resident. She has a pressure ulcer on the coccyx area, and she got it here in the facility, but it was here before I ever started working here which was about 6 months ago." V14 removed the soiled beige colored bandage/dressing cover that had no date or markings on the bandage to identify when the dressing was changed or who changed the dressing. V14 continued and removed the bandage to reveal the wound. V14 stated, "It measures approximately 3 centimeters by 2 centimeters wide and 1 centimeter deep." Surveyor asked to describe the wound size further to the surveyor, V14 stated, "I'd say it is smaller than a golf ball size but bigger than a marble. First, I clean it with normal saline solution and then I pack the wound with the silver alginate dressing, then cover it with the foam dressing (bandage cover)." As V14 was cleaning R16's wound with the normal saline, R16 twitched her body forward and made a moaning sound. As V14 started packing R16's wound with the silver	S9999		

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S9999	Continued From page 7 alginate dressing, R16 retracted her body again and moaned. Surveyor asked about the movements and sounds R16 made, V15 stated, "She does that all the time when we change her dressing." V14 added, "She is has overall pain; but she gets regular scheduled pain medications later on." Surveyor asked if the movements and sounds R16 made were pain responses and whether he should have stopped the procedure or pre-medicated her before doing the wound care, V14 stated, "I think she is like that, but I did it pretty quickly, so I don't think she was in pain." Surveyor asked to clarify what clinical stage R16's wound was, V14 stated, "It is a stage 3 pressure sore." Surveyor asked to clarify the staging of the wound, V14 stated, "Yes it's a stage 3 not a stage 4, that's what it looks like to me." Surveyor asked why there were no initials or date placed on the dressing cover to denote when the wound dressing was changed, V14 stated, "We were told not to do that, but I knew it was changed because I changed it yesterday." Surveyor asked if this was considered best nursing practice to not date wound dressings when they are done, V14 stated, "I guess it would be sir, but we never do that here." Surveyor asked whether R16 had any other wounds, V14 stated, "Yes, it is on her right trochanter hip area, but it is almost healed." V15 turned R16 to her side to reveal another undated and un-initialed wound dressing on R16's right hip area. V15 proceeded to peel off the wound dressing to show surveyor until surveyor asked V15 to stop what she was doing. Surveyor asked V14 if V15 was a nurse and allowed to do wound care, V14 stated, "No. She is not a nurse and should not be doing that because she is not licensed." Care plan #1 dated 8/4/22 reads in part, "The resident has a stage 4 pressure injury on sacrum.	S9999		

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S9999	Continued From page 8 Goal: Sacral pressure injury will not increase in size. Interventions: The resident requires the bed as flat as possible to reduce shear; Keep skin free of moisture; Monitor the area for any signs of infection; treat the area as ordered; Treat pain as per ordered prior to treatment/turning etc. to ensure the resident's comfort. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate." Care plan #2 dated 7/5/22 (revised 11/30/22) reads in part, "The resident has arthritis and chronic pain and is at risk for complications. Goal: The resident will be/remain free of complications related to arthritis related joint impairment. Interventions: Educate resident on joint conservation techniques. Encourage adequate nutrition and hydration. Give analgesics as ordered by physician. Monitor and document for side effects and effectiveness. Heat/cold applications as ordered and as tolerated. Monitor/document/report to MD as needed for signs and symptoms related to arthritis: joint pain, usually worse on wakening." Care plan #3 dated 7/5/22 (revised 11/30/22) reads in part, "The resident is at risk for pain related to osteoarthritis, history of CVA with right hemiplegia, dementia, chronic wound. Goal: There resident will experience comfort. Interventions: Medicate per physician orders. Monitor for signs and symptoms of pain. Offer massage; Turn and reposition." Records reviewed showed no other care plans to manage pain during wound care for R16. A wound evaluation report provided to surveyor by V1 (Administrator) and submitted by V18	S9999		

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S9999	Continued From page 9 (Wound Doctor) dated 11/11/2022 shows in part, "(R16) Focused wound Exam (site 1) Stage 4 press wound sacrum full thickness. Etiology (quality): Pressure; MDS 3.0 Stage 4; Wound size (Length x Width x Depth) 2.6 x 1.8 x 0.3 cm.; Surface area 4.68 centimeters squared. Wound progress: Deteriorated. A recent wound evaluation report also provided by V1 and submitted by V18 dated 2/10/2023 shows in part, ""(R16) Focused wound Exam (site 1) Stage 4 press wound sacrum full thickness. Etiology (quality): Pressure; MDS 3.0 Stage 4; Wound size (Length x Width x Depth) 2.7 x 1.6 x 0.3 cm.; Surface area 4.32 centimeters squared. Wound progress: No Change. Plan of care reviewed and addressed. Recommendations: Off-load wound; reposition per facility protocol." Care plan dated 8/4/22 reads in part, "The resident has a stage 4 pressure injury on sacrum. Goal: Sacral pressure injury will not increase in size. Interventions: The resident requires the bed as flat as possible to reduce shear; Keep skin free of moisture; Monitor the area for any signs of infection; treat the area as ordered; Treat pain as per ordered prior to treatment/turning etc. to ensure the resident's comfort. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate." Another care plan dated 7/5/22 (revised 10/5/22) reads in part, "The resident has an ADL (activities of Daily Living) self-care performance deficit related to CVA (Cardiovascular accident) with hemiplegia. Goal: The resident will maintain current level of function through the review dated. Interventions: Bed mobility: The resident needs total assist of 2 staff. Bathing/Showering: The	S9999		

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resident needs 2 person assist; Personal hygiene: The resident needs total assist with minimum 2 person assist."

On 2/16/23 at 10:40 AM, interview with V3 (ADON/Assistant Director of Nursing and wound care nurse) stated, "I am the wound nurse and ADON. I've been the wound nurse since 2021. I am wound care certified. I do rounds with V18 (Wound Doctor) every Friday. Mostly the nurse on the floor does the wound care. They do the wounds everyday except Friday when I do them." Surveyor asked about R16, V3 stated, (R16) she is nonverbal and stays in bed, NPO (nothing by mouth), and she has feeding tube. She requires minimum two people with all ADL's (Activities of Daily Living). She has stage 4 in the sacrum, and it was acquired here in the facility. The wound has remained a stage 4 for two years. It is a chronic wound, and it is not deteriorating, it is stable." Surveyor asked about pain management of wounds, V3 stated, "When we do wound care for (R16), she is not pre medicated for pain. She has scheduled medications, but we don't pre-medicate for pain but if she doesn't have any, but I will do that from now on."
Surveyor asked based on her training and clinical knowledge why the wound wasn't healing, V3 stated, "She has multiple diagnosis she is anemic diabetic, hemiplegia. We are doing daily treatments and wound doctor is overseeing it. The treatment was changed multiple times. She is on air mattress, urinary catheter; We are changing her positions every two hours and the CNAs are repositioning her." Surveyor asked how she monitored compliance with these orders for turning and repositioning, V3 stated, " I have seen them turning her. I work here 8-4:30 PM so I eyeball it. It takes two people to reposition her, and they CNAs are doing pericare when she is

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soiled so they turn and reposition her then and as needed." Surveyor asked if it was important to reposition R16 and whether that had any impact on delayed healing if it was not being done, V3 stated, "I don't know." Surveyor asked how many times in the day R16 would require repositioning, V3 stated, they reposition her every shift so 4 times a day she is turned." Surveyor asked about dating and initialing of wound dressings when rendered, V3 stated, "We don't date or initial wound dressings because our corporate say not to and it is in our policy." Surveyor asked about the training of the nurses since wound care is done 6 out of the 7 days by the floor nurses, V3 stated, "I don't know about their training. I communicate to the nurses the type of wound." Surveyor asked if she directly trained the floor nurses about wound care, V3 stated, "No I just tell them about the wound and a year ago in a job fair, I told them." Surveyor asked about the wound training of the agency nurses on the floor, V3 stated, "I don't know but they should know." Surveyor asked since she was a Certified wound nurse and based on her own wound training and clinical background whether the wound was an avoidable wound, V3 stated, "I think that this wound was preventable because if she would not be on hard surface for a long time or if she could be more up from bed and from the wheelchair or sitting position and changing positions, it could have been prevented. Positioning is important and nutrition." Surveyor asked about pain management of wounds, V3 stated, "When we do wound care for (R16), she is not pre medicated for pain. She has scheduled medications, but we don't pre-medicate for pain but if she doesn't have any, but I will do that from now on."

On 2/16/23 at 4:00 PM, Surveyor reminded V3 to provide the policy where it indicates to not initial

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S9999	Continued From page 12 or date the dressing when it is accomplished V3 stated, "I thought the DON (V2) gave you that." Surveyor asked V3 if she considered it a best practice to initial and date when a dressing is done, V3 stated, "I don't know. I can't answer that." On 2/16/23 at 4:10 PM, V2 (Director of Nursing) was asked about dating and initializing when changing wound dressings, V2 stated, "It is considered best practice to initial and date when a wound dressing has been changed." Efforts to reach V18 were unsuccessful and was informed by V1 and V3 that V18 was on vacation and was possibly unreachable because V18 was in the mountains. V1 offered surveyor contact information for R16's primary physician and for the facility's medical director. Efforts to reach the V19 (Primary physician) were met with the answering service informing surveyor that only a covering doctor was available to be paged if there were orders needed by the nursing home facility. On 2/16/23 at 4:30 PM, interview with V24 (Medical Director) stated, "I am informed of any acquired wounds as the Medical director, and we go over this topic during our monthly quality assurance meetings. When it comes to pressure ulcers we talk about any facility-acquired pressure sores and especially anything above a stage 2 where we talk about root cause, and we develop interventions to prevent and heal these wounds." Surveyor asked that since they talk about wounds higher than a stage 2, what his feedback was about (R16). V24 stated, "I do recall this resident being discussed but please refresh my memory." Surveyor provided brief information about R16	S9999		

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	IL6000046	A. BUILDING: _____ B. WING _____	02/16/2023

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S9999	Continued From page 13 and asked the importance of turning and repositioning for R16 as ordered by the Primary physician (V19). "Turning and repositioning is an important preventative measure but once the wound develops however, it is crucial now for turning and repositioning to be done." Surveyor asked about the specialty air mattress and how the bed should be prepared, V24 stated, "I really couldn't speak to that however I do know that the bed should be made minimally to prevent over padding of sheets, etc. to prevent pressure area and to attempt better healing." Surveyor asked if nurses should be indicating on the wound dressing who or when the dressing was changed, V24 stated, " I am not that familiar with nursing practice however, I do consider it would be best practice to initial and date a wound." Surveyor asked whether, CNAs were allowed to do dressing changes, V24 stated, "I would not think they are allowed to do so unless they are licensed nurses. " Surveyor asked about pain management during wound care, V24 stated, "From what I know about pain management, and assuming that the cognitive impaired resident is unable to ask for pain medications, it would be appropriate and good practice to administer pain medication approximately 30 to 45 minutes before dressing changes are done. If a patient shows signs of discomfort and retracts during wound care then pain medication should have been provided prior to this procedure and if there were signs of moaning or retracting when the procedure was being done, that procedure should have been immediately stopped." Facility policy dated 6/1/21 titled "Pressure ulcer-wound assessment and documentation" reads in part, "Wound assessment is a continuous process that serves to provide information about wound status, staging, its	S9999		

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S9999	Continued From page 14 etiology, and the efficacy of the interventions. Purpose: to report and gather data for the purpose of planning and implementing wound (specifically pressure injuries treatment procedures. Procedure: Identify resident, explain procedure, obtain consent for photograph, and ensure privacy. Wash hands before and after procedure. Apply gloves before performing wound assessment. remove and discard dressing and gloves. Wash and apply new gloves. Stage 4 Pressure injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure injury. The staff nurse identifying the wound shall make initial measurements. Measurement of the wound should occur weekly. The wound care/designated staff nurse should assess the resident upon identification of impairment in skin integrity and subsequently with any change in appearance. The staff nurse shall assess the wound weekly and notify the wound care nurse/designated staff nurse and physician of any changes/deterioration." Facility policy dated May 19, 2022, titled "Pain assessment, long-term care" reads in part, "Pain is defined by the International association for the study of pain as an unpleasant sensory and emotional experience associated with (or resembling that associated with) actual or potential tissue damage... It's crucial for nurses to communicated with other health care providers and assess and address resident's pain because residents are more likely to return to baseline with	S9999		

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S9999	Continued From page 15 early recognition and treatment of pain. Inadequate treatment of pain is associated with many adverse outcomes among long-term care residents, including falls, disrupted sleep and eating, decreased socialization, reluctance to participate in normal activities, impaired mobility, and symptoms of depression, anxiety or both. The assessment, identification, and treatment of pain are important components of a resident care plan and an ethical part of nursing care. Nurses must conduct comprehensive pain assessments that are consistent with resident's age, medical condition and mental status. In addition, residents have the right to treatments and interventions to reduce pain. Pain is commonly under-treated in residents with cognitive impairments such as dementia. Pain assessment in these residents requires the use of a facility-approved tool, such as the Pain Assessment in Advanced Dementia scale, which focuses on observing the resident's behaviors." An ostomy wound management abstract research paper dated February 2009, titled "Pressure Ulcer Pain: A Systemic Literature Review and National Pressure Ulcer Advisory Panel White Paper" research article reads in part, "Pain is an ever-present problem in patients with pressure ulcers. As an advocate for persons with pressure ulcers, the National Pressure Ulcer Advisory Panel (NPUAP) is concerned about pain. To synthesize available pressure ulcer pain literature, a systematic review was performed of English language literature, specific to human research, 1992 to April 2008, using PubMed and the Cumulative Index in Nursing and Allied Health Literature. Fifteen relevant papers were found; they examined pain assessment tools, topical analgesia for pain management, and/or descriptions of persons with pressure ulcer pain.	S9999		

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S9999	Continued From page 16 Studies had small sample sizes and included only adults. The literature established that 1) pressure ulcers cause pain; 2) pain assessment was typically found to be self-reported using different versions of the McGill Pain Questionnaire, Faces Rating Scale, or Visual Analog Scale; 3) pain assessment instruments should be appropriate to patient cognitive level and medical challenges; 4) in some cases, topical medications can ease pain and although information on systemic medication is limited, pain medications have been found to negatively affect appetite; and 5) wound treatment is painful, particularly dressing changes. Persons with either Stage III or Stage IV pressure ulcers had significantly ($P < 0.05$) more severe pain (i.e., MPQ total and sensory and affective subscales) than persons with other wounds." (B)	S9999		