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 |
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| | IL6008825 | A. BUILDING: ______ B. WING ______ | C 07/19/2024 |

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| **WARREN BARR SOUTH LOOP** | **1725 SOUTH WABASH CHICAGO, IL 60616** |

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| S 000 | Initial Comments | S 000 | | |
| S9999 | Final Observations | S9999 | | |

S 000 Initial Comments

Complaint Investigation -

2485084/IL174955
2485363/IL175331

S9999 Final Observations

Statement of Licensure Violations:

300.610a)
300.1010h)
300.1210b)
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 300.1010 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,

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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 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:

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,

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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 record reviews and interviews the facility failed as follows: failed to follow preventive measures in placing intervention of skin moisture barriers as per facility policy; failed to follow Wound Nurse Practitioner recommendation for dietitian to consult and assess in a timely manner; failed to provide interventions of multivitamin and zinc sulfate per Wound Specialist Assessment; failed to provide protein supplement due to delay of nutritional assessment; and failed to ensure orders by Wound Nurse Practitioner for laboratory testing and antibiotic therapy was carried out. All failures apply to 1 out of 4 residents (R1) in a total sample of 4 residents reviewed for prevention and treatment of pressure injuries. These failures affected 1 resident (R1) and resulted in R1 sustaining pressure injuries and R1's transfer to hospital due to sepsis/infection of pressure injuries.

Findings include:

R1 is 78 years old, initially admitted in the facility on 5/7/2024. R1's medical diagnosis includes anoxic brain damage, reduced bed mobility and seizures. V13 (Agency Licensed Practical Nurse) progress notes dated 6/25/2024, documents that R1 transported to the hospital by two (2) paramedics going to the Emergency Room (ER).

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V14 (Licensed Practical Nurse) progress notes dated 6/25/2024, documents that R1 was admitted to the hospital with diagnosis of sepsis.

On 7/16/2024 at 2:28 PM, V9 (Family of R1) stated that on 6/22/2024 her brother V10 (Family of R1) visited R1 in the facility. During the visit V10 smelled a foul odor on R1 and requested the nurse to change the dressing. V9 stated that she spoke to V8 (Wound Coordinator / Licensed Practical Nurse) and that V8 assured her that it was not an infection. V9 stated that R1 was admitted in the hospital for sepsis of the wound and was treated with a lot of antibiotics until currently. On 7/19/2024 at 1:08 PM, V10 confirmed and stated that he saw the wound, it looked really bad and smelled of foul odor during his visit on 6/22/2024.

V4 (Nurse Practitioner for Wound) progress notes dated 6/25/2024, the day R1 was transferred to the hospital, showed R1's wound was worsening, it has malodorous, and R1 has elevated temperature.

History of R1's skin documentation are as follows:

Per initial assessment by the facility dated 5/8/2024, R1's skin was intact. R1 was transferred to the hospital on 5/13/2024 due to coffee brown emesis and came back from the hospital to the facility on 5/15/2024.

On 5/16/2024, R1 was seen and was assessed initially by V4 (Nurse Practitioner for Wound). V4 documented that R1's skin was intact, though there are few blanchable redness on the perineal areas. V4 recommended that facility follows preventive measures which includes application of topical moisturizer daily and incontinent /

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moisture barrier cream every shift and as needed.

Physician Order Sheet (POS) of R1 documents that both skin barrier treatments which are topical moisturizer scheduled daily and incontinent / moisture barrier cream scheduled every shift were not included in the order after R1 was readmitted on 5/15/2024.

On 5/31/2024 per facility assessment, R1 sustained three unstageable pressure ulcers. They were located on the sacrum with measurement of 5 by 3 centimeters, left gluteal (buttock) with measurement of 3.5 by 3 centimeters, and right gluteal (buttock) with measurement of 5.5 by 4.5 centimeters.

On 6/4/2024 per V4's progress notes and wound assessment, R1 was seen and assessed with wounds the same measurements as per facility assessment. Per V4 all wounds have slough (a mass or layer of dead tissue separated from the surrounding or underlying tissue). V4 recommends that R1 needs nutritional consult for presence of wounds due to risk for wound complications.

On 6/11/2024 per V4's progress notes and wound assessment, V4 reiterated again her recommendation of the need for R1's nutritional consult for presence of wounds due to risk for wound complications.

Per progress notes R1 was seen by V12 (Registered Dietitian) on 6/17/2024. Eighteen (18) days after R1 was identified on 5/31/2024 with three (3) unstageable pressure injuries; and after multiple recommendation by V4 on 6/4/2024 and 6/11/2024.

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V4's wound assessments of R1 dated 6/25/2024 documents that R1's sacrum wound extends to the left gluteal area and was worsening. On V4's progress notes with the same date, it was documented that the wound of R1 is warm to touch and was worsening. Wound has large area of eschar, and R1 has a fever, with malodorous smell. V4 recommends antibiotic therapy for infection depending on the outcome of laboratory test results. V13 (Agency Licensed Practical Nurse) progress notes on change of condition dated 6/25/2024, documents that R1's temperature 100.9 Fahrenheit and pulse rate of 114 beats per minute were out of the normal range.

On 7/17/2024 at 10:39 AM, V8 (Wound Coordinator / Licensed Practical Nurse) stated that R1 was initially admitted on 5/7/2024 and was transferred to the hospital on 5/13/2024. R1 returned back in the facility on 5/15/2024 and the wound care team with V4 (Nurse Practitioner for Wounds) saw R1 on 5/16/2024. During this time R1 had no pressure ulcer when assessed on 5/16/2024. R1 has a Braden score of 5 that means R1 is at high risk for alteration of skin integrity. V8 stated that cream barriers help to prevent resident from developing pressure ulcers. V8 was asked related to cream barriers not included in the physician order after re-admission on 5/16/2024. V8 after reviewing R1's treatment administration record (TAR) for the month of May 2024 stated, "I am not sure why it was not placed there upon re-admission. It would help if that was in the order, applying topical cream is more focus than just changing a diaper." V8 also said that there is no specific assessment in a schedule basis if a resident does not have wound. The wound care team did the assessment on

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5/31/2024 because R1 has skin alteration, and it was the first time R1's pressure ulcers were identified. V8 stated that R1's pressure ulcers were unstageable because there was slough that makes the wound not able to be determined for its depth. V8 stated that on 6/25/2024 when wound care team saw R1's pressure ulcers that was the time it got worst. Per V8 there was the merger of two (2) pressure injury sites of the sacrum extending to the left buttock. Upon changing the dressing R1's pressure ulcers had foul odor and granulating tissue had decreased. V8 clarified that granulating tissue are good tissue that helps the wound heal. During this time V4 ordered labs that included STAT (to be performed right away) CBC (complete blood count), CMP (comprehensive metabolic profile), ESR (erythrocyte sedimentation rate), pre-albumin, and culture of the wound. V8 was asked if all of these orders were carried out and performed. V8 reviewed all orders of R1 and said, "I don't see all the orders only CBC, CMP and urine culture." V8 said that V4 also ordered antibiotic therapy but was not sure if it was done. V8 said that R1 was transferred to the hospital and was admitted with diagnosis of sepsis. Per World Health Organization (WHO) fact sheet dated 5/3/2024, sepsis is a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction. The body's reaction causes damage to its own tissues and organs, and it can lead to shock, multiple organ failure and sometimes death, especially if not recognized early and treated promptly.

On 7/17/2024 at 11:54 AM, V2 (Director of Nursing) stated that nursing staff has no formal skin assessment done as scheduled. Best practice is for nursing staff to assess resident

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during ADL (activities of daily living) care on their shower day and CNAs (Certified Nursing Assistants) to notify nurses immediately when there is a change on a resident skin. V2 said she is not familiar with R1.

On 7/17/2024 at 1:45 PM, V8 provided a form titled Wound Specialist's Assessment of Ulcer Avoidability / Unavoidability for R1. V8 stated that V2 (Director of Nursing) instructed V8 to give the form to writer. The form document as follows: Wound sites of R1: Sacrum, Left Buttock, and Right Buttock with date of onset for all pressure injuries on 5/31/2024. Under interventions, R1 needs the following medications and supplements: Multivitamins, Zinc Sulfate, Nutritional Supplements, and use of pain medication to allow repositioning. Form further documents that because of the above risk factors and because despite the provision of above preventive interventions, the sore still developed, the sore is therefore considered unavoidable. Because the sore which was acquired from the hospital/other home and was provided with above proper interventions still deteriorated, this ulcer is therefore unavoidable.

Upon review of R1's record the following were established: - Per physician order record and history, R1 was never given multivitamins and zinc sulfate. R1 was not receiving Pro Stat, protein supplement from the time pressure injuries were identified on 5/31/2024 and was ordered; and not until 6/17/2024. Despite V4 (Nurse Practitioner for Wound) recommendation on 6/4/2024, 6/11/2024 and 6/18/2024 for nutritional consult. R1 was not seen by dietitian until 6/17/2024.

On 7/18/2024 at 10:15 AM, V4 (Nurse

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| S9999 | Continued From page 8<br>Practitioner for Wounds) stated that cream barrier helps to prevent moisture build up and prevent skin alteration. When R1's pressure injuries were identified they were unstageable because it cannot be determined how deep the wound is due to present of slough. When slough is removed it will either be stage 3 or 4 and never be stage 1 or 2 because of the depth of the wound. When asked if unstageable is considered late stage of the wound? V4 stated that it can be late stage of pressure injury because there are stages 1 and 2. Unless there is an underlying factor underneath the wound. V4 stated that protein intake is very important to the healing of the wound and also zinc in the diet. Protein helps with amino acid build up and helps with tissue rebuilding. Yes, I recommended to evaluate R1's nutrition by the dietitian since I first saw the wounds on 6/4/2024. It will take time to absorb nutritional supplement. V4 was asked since it takes time for nutritional supplement to be absorbed will it be beneficial to start R1 as early as possible? V4 did not address the question, and said nutrition is not enough to prevent wound from deteriorating. Document titled Wound Specialist's Assessment of Ulcer Avoidability / Unavoidability for R1 was presented to V4 to verify and acknowledge the form. V4 stated that she was aware of the form. V4 was informed that under interventions multivitamins, zinc sulfate was supposed to be given to R1 but were not ordered in the physician orders. And Pro Stat was not ordered until 6/17/2024 although R1's pressure injuries were identified on 5/31/2024. V4 stated that she does not know that because she does not check each and every order of resident. V4 was asked to verify the date of the form and stated that it is 5/18/2024. V4 was asked that in the form pressure injuries of R1 are unavoidable but in R1's progress notes with the same date | S9999 | | |

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(5/18/2024) all 3 (three) pressure injuries are improving? V4 stated that it is the facility staff who fill in the unavoidable form and she just signed it. Surveyor also pointed out another discrepancy to V4 that under the form/document, pressure injuries were acquired from hospital or other homes. V4 said that all pressure injuries were facility acquired and not acquired elsewhere. V4 stated that on the day that she assessed R1 on 6/25/2024, R1's pressure injuries had malodor that was pretty intense and when there is odor to the wound there is infection. I (V4) ordered labs that includes CBC with differential, CRP, ESR and antibiotic treatment; and cannot remember if she ordered a wound culture. V4 was informed that the physician order sheet does not reflect all lab orders and R1 has no order for an antibiotic. V4 stated that it seems that there is lack of coordination. V4 stated, "I told the girls (wound care team), PCP (Primary Care Physician) and DON (Director of Nursing) about R1's wound status and those orders." V4 stated that the information she gave directed the nursing staff to assess R1 and R1 was ordered to transfer to the hospital. R1 was admitted in the hospital for sepsis of the wound.

On 7/18/2024 at 12:25 AM, V8 admits filling out the form (Wound Specialist's Assessment of Ulcer Avoidability / Unavoidability for R1) that V4 signed. V8 stated that dietitian was informed that R1 needs dietary consult but does not know why it took her until 6/17/2024 to see R1.

On 7/18/2024 at 12:43 PM, V12 (Registered Dietitian) stated that resident needs protein if they are not getting enough protein via tube feeding. Amino acid helps with rebuilding tissue or regenerating tissue. R1 needs also zinc and multivitamins. V12 stated that after R1 sustained

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pressure injuries it was on 6/17/2024 that she (V12) saw R1 for nutritional consult. V12 then stated that R1 was at risk for malnutrition due to prolong use of enteral feeding.

Per article of National Library of Medicine, dated 3/24/2022, it reads that proteins provide the main building blocks for tissue growth, cell renewal, and repair during wound healing.

Skin Care and Regimen and Treatment Formulary policy dated 1/24/2024, reads: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Under prevention, the facility will provide topical moisturizer to be applied daily and as needed. Facility will also provide incontinent / moisture barrier cream every shift and as needed.

Facility policy does not provide assessment schedule for early identification of wounds. V1 (Administrator) and V2 (Director of Nursing) were requested for policy and/or procedure of skin assessment schedule. V1 and V2 stated that facility does not have any policy or procedure related to skin assessment schedule.

(A)