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	IL6000210	A. BUILDING: _____ B. WING _____	C 07/30/2024

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ACCOLADE HEALTHCARE DANVILLE	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

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S 000	Initial Comments Complaint Investigation 2465764/IL175884	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1210 General Requirements for	S9999		

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S9999	Continued From page 1 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. 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: 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 interview and record review the facility failed to routinely assess and monitor a bruise/hematoma (bruising with blood pooling underneath the skin), update the physician, and assess and measure post-surgical wounds upon readmission for one of three residents (R1) reviewed for wounds in the sample list of four. This failure resulted in R1's left foot	S9999		

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bruise/hematoma becoming infected and requiring hospital operative incision and draining (I&D).

Findings include:

R1's Care Plan dated as reviewed 5/13/24 documents R1's diagnoses include Peripheral Vascular Disease and Type 2 Diabetes Mellitus.

R1's Nursing Note dated 6/1/2024 at 9:48 AM documents a fresh, purple bruise was found on the top of R1's left foot that measured 3 centimeters (cm) by 1 cm. R1 reported that R1's foot was likely bumped during R1's mechanical lift transfer yesterday.

R1's Weekly Skin Assessment dated 6/4/24 documents R1's anterior foot bruise measured 5 cm by 2.5 cm and there was no break in skin. R1's Weekly Skin Assessments dated 6/11/24 and 6/18/24 document there were no new or worsening skin conditions, but there is no documentation of R1's left foot bruising or a description of this area. R1's electronic medical record (EMR) does not contain documentation that R1's foot bruising was reported to a physician after 6/1/24 or assessed by a physician until R1's hospitalization on 6/19/24. There are no documented assessments or monitoring of this bruise after 6/4/24 until after R1 was hospitalized on 6/19/24.

R1's Hospital History & Physical dated 6/20/24 documents on 6/19/24 R1 presented with left foot swelling, fluctuance (boggy feeling due to buildup of fluid), redness and warmth. R1's admitting diagnoses included septic shock and left foot abscess, and intravenous antibiotics were initiated. R1's Infectious Disease Note dated

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6/26/25 documents R1 was in septic shock secondary to gram negative bacteria and the source of the infection is gastrointestinal versus left foot infection. This note documents on 6/23/24 purulence was expressed from R1's abscessed hematoma and a large hematoma was operatively removed.

R1's Readmission Nursing Assessment dated 7/6/24 documents R1 had "multiple" stage one pressure ulcers on the right outer foot. There is no documentation to indicate how many wounds, wound characteristics, or measurements. R1's Weekly Skin Assessment dated 7/7/24 documents three pressure sores to left lateral foot/ankle and sutures to the top left foot where a hematoma was prior to hospitalization. This assessment does not document measurements or wound descriptions for these wounds. There are no other documented assessments for these wounds after 7/6/24 until 7/9/24 when R1 was evaluated by V3 Registered Nurse (RN)/Wound Nurse.

R1's Wound Assessment Details Report dated 7/9/24 documents the following: R1's left dorsal (top) foot full thickness surgical wound measured 1.5 cm by 1.3 cm. R1's left proximal dorsal vascular wound measured 1.9 cm by 1.3 cm. R1's left distal, lateral (side) unstageable pressure ulcer measured 2.2 cm by 0.9 cm. R1's left proximal, lateral foot unstageable pressure ulcer measured 2.5 cm by 1.3 cm.

R1's Wound Assessment and Plan dated 7/11/24, recorded by V18 Wound Physician, documents these wounds are related to an avulsion injury (skin tear), and this was the initial consultation by V18 for R1's left foot hematoma.

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S9999	Continued From page 4 On 7/29/24 at 10:35 AM V4 RN stated on 7/17/24 R1 had open areas to the left foot and one with sutures due to a hematoma that was lanced during R1's prior hospital stay in June 2024. On 7/29/24 at 11:56 AM V4 confirmed V4 completed R1's skin assessment on 7/7/24. V4 stated at that time R1's left foot wounds were red with callous like tissue and were not open. V4 stated V3 Wound Nurse is responsible for obtaining and documenting wound measurements and assessments. On 7/29/24 at 1:04 PM V4 stated R1's left foot bruising was red/purple in color, was swollen with blood collected forming a bump. V4 stated the area stayed the same from when it was first identified until R1 was hospitalized in June, and the area had not shown any signs of improvement. V4 stated there should be documented monitoring and assessments for this area recorded on the Treatment Administration Record or progress notes. On 7/29/24 at 12:00 PM V5 RN confirmed V5 completed R1's readmission assessment on 7/6/24. V5 stated V5 incorrectly documented R1's left foot wounds as the right foot. V5 stated V5 did not obtain measurements of the wounds which V5 described as multiple stage one pressure ulcers that were reddened and not open. V5 stated V5 was unsure how many wounds were present since V5 did not document that information. V5 stated V5 reported these wounds to V3. V5 stated wounds should be documented on the readmission assessment, but usually V3 obtains and documents the wound assessment. V5 stated if V3 is not here, then V3 completes the assessment the next day. V5 confirmed V3 was not on duty when R1 readmitted to the facility and V5 did not document a thorough assessment of R1's foot wounds.	S9999		

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On 7/29/24 at 12:49 PM V3 RN/Wound Nurse stated the nurses should notify V3 of newly identified wounds and when V3 is not in the facility the nurses should notify the physician and document a description/assessment of the wound. V3 stated the protocol is the same for when residents are new admissions or readmissions to the facility. On 7/29/24 at 1:24 PM V3 stated R1 returned from the hospital with two wounds on the lateral and two wounds on the dorsal sides of her foot, which were closed when R1 readmitted. V3 stated R1 also had sutures to the top of her left foot where the hematoma was. V3 stated V3 evaluated R1's wounds on 7/9/23 since R1 readmitted on a Saturday. V3 stated V3 initially thought the wounds were pressure ulcers that were scabbed areas, but V18 classified them as vascular. V3 stated the bruise/hematoma was not in (wound monitoring software) for monitoring prior to R1's return from the hospital, and V3 was not aware of R1's bruise/hematoma since V3 had been on vacation until 6/10/24. V3 stated the nurses should have been monitoring the area and documenting a weekly description on the weekly skin assessments, including color and other characteristics, until it was resolved. V3 confirmed the nurses should have notified the physician if the area was not improving or if it had worsened. V3 stated physician notification is documented in the nursing notes.

On 7/29/24 at 3:43 PM V15 Nurse Practitioner stated R1 was hospitalized in June for sepsis that was caused either from the hematoma or bowel related. V15 stated the facility staff should have been monitoring and assessing R1's hematoma, including characteristics, measurements/assessments, and monitoring for fever. V15 stated the area should have been monitored daily and the staff should have made

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sure it was healing and had no signs of infection. V15 stated V15 was not aware of R1's left foot hematoma prior to R1's hospital I&D and V15 relies heavily on the nurses to report things. V15 stated V18 should have been notified as well of any decline in the wound or if no signs of improvement. V15 would have referred R1 to be seen by V18 if V15 was made aware, and it is a "strong possibility" that R1's hospital I&D may have been prevented if R1 was evaluated by V18 and antibiotics were ordered.

On 7/29/24 at 3:55 PM V18 Wound Physician stated 7/11/24 was V18's initial evaluation of R1's foot wounds and R1 had four left foot wounds at that time. V18 stated R1 had been previously hospitalized for the left foot hematoma and R1's wounds were not pressure related. V18 stated V18 coded the wounds as avulsions which were the result of the hospital I&D. V18 stated the facility should have been monitoring the hematoma and notified V18. V18 stated V18 would have lanced and drained the hematoma at the facility, which could have prevented R1's hospital I&D. R1 stated the nurses should be documenting thorough wound assessments at the time of admission/readmission.

On 7/30/24 at 1:00 PM V2 Director of Nursing stated V2 looked through the medical records and has no additional documentation to provide.

The facility's Bruises and Rashes policy dated April 2023 documents significant bruises will be monitored in (wound monitoring software) weekly until healed and physician notification will be completed.

The facility's (wound monitoring software) policy dated April 2023 documents the admitting nurse

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S9999	Continued From page 7 will document the presence of wounds on the nursing admission form and obtain a treatment order. This policy documents the wound nurse is responsible for documenting the wound measurements/description and interventions and reviewing treatment orders within 72 hours. The facility's Physician Notification of Resident Change Of Condition dated 8/2/24 documents the charge nurse is responsible for notifying the resident's physician of changes in the resident's condition, and documenting the change and notification in the resident's medical record. This policy documents the resident will be placed on the 24 hour report for close monitoring of condition each shift. (A)	S9999		