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S 000	Initial Comments Complaint Investigation 2446901/IL177330	S 000		
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, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999		

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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, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not

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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 ae not meet as evidenced by:

Based on interview, observation, and record review, the facility failed to prevent, identify, assess, monitor, implement progressive interventions, and to handle soiled pressure ulcer dressings appropriately to prevent pressure ulcers and encourage healing for 2 of 3 residents (R2, R3) reviewed for pressure ulcers in the sample of 6. This failure resulted in R2 going for 9 days without a treatment in place for a left heel pressure ulcer and R3 having one pressure ulcer on the left medial foot that was unknown by staff, one pressure ulcer on the left great toe that did not receive treatment or a full assessment for 9 days and R3 developing osteomyelitis requiring Intravenous Antibiotics.

Findings include:

1. On 9/3/24 at 8:41 AM, V7, Certified Nurse's Aide (CNA) and V8 CNA are in R3's room in the middle of cleaning her up. R3 is lying on her left side. R3 has a visible sacrum pressure ulcer approximately 4 inches (in) by (x) 3 in x 2.5 in deep. The old dressing has yellow brown drainage on it. The dressing is on the bed near R3's mid back. The dressing is dated 9/3/24. The pressure ulcer has packing that has come out of the pressure ulcer that is lying on the bed. V8 removed all of the dressing packing, crumpled into her gloved hand, placed it back into the

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pressure ulcer wound bed, and reapplied the old dressing. R3 did not have pressure relieving boots on her feet.

On 9/3/24 at 8:49 AM, V7 and V8 were questioned how long R3 has had the pressure ulcer, V7 stated, "She has had it for a while. It requires multiple changes a day because it drains so much. "

On 9/3/24 at 9:27 AM, V4, Wound Nurse, stated, "I helped for 4 weeks (as wound nurse) and then I asked to step down. This morning, I have accepted to take on the role again. I have not seen the wound recently. She has been seen by Infectious Disease (ID) and Plastics for debridement. The last time I saw it, it was full of slough, so it was hard to tell how deep it was." V4 removed the old dressing and packing, cleansed the wound bed with wound cleanser, packed the wound bed with gauze soaked in normal saline, and covered it with an abdominal pad. The periwound has an extended area around the wound bed that is light red with splotchy darker red areas. V4 stated, "I think that (reddened periwound) was caused by the previous dressing we were using." The wound bed is light red with a minimal amount of slough. V4 was questioned if she thought the pressure ulcer was approximately 4 in (10.16 centimeters (cm)) x 3 in. (7.62 cm) x 2.5 in. (6.35 cm), V4 agreed to the approximate size.

On 9/3/24 at 9:45 AM, V4, stated, "(V8) should have not removed the packing or put the old dressing back on."

On 9/3/24 at 1:31 PM, V2, Interim Director of Nurses, was questioned if she could go to R3's room so R3's feet could be observed. R3 was

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lying on her right side, there is a pillow between her knees, her right lateral foot and left medial foot are lying directly on the mattress. R3's left Great toe on the medial side has a necrotic pressure ulcer approximately 1 cm by 0.5 cm and the left medial foot below the toe has a necrotic pressure ulcer approximately 0.5 cm x 0.5 cm. The 2 pressure ulcers did not have any dressings on them. R3 was not wearing any pressure relieving boots on her feet.

On 9/3/24 at 3:10 PM, V7, CNA, was questioned how long R3 had pressure ulcers on her left foot, V7 stated, "It's been a while. I lose track of my days, but she has had them for a while. They come and go." V7 pointed out that the right foot has red blotches on them, V7 stated, "They get worse the more contracted she becomes."

On 9/3/24 at 3:29 PM, V3, Licensed Practical Nurse / Minimum Data Set Nurse (LPN/MDS), stated, "(R3's) pressure ulcer started out on the left ischial tuberosity. It was almost healed. I was off for the weekend and when I came back it had opened back up and had gotten progressively worse. It started out small and turned into a larger area and that is when we started calling it a sacrum wound. I believe the wound doctor was seeing her the entire time. We had a team of nurses come from (a sister facility) and do a house wide sweep of resident's skin on 8/14/24. I was given a list of residents that had pressure ulcers that were not identified previously. She was on that list with a pressure ulcer on her left foot. I was not in charge of pressure ulcers at the time (V4) was. I was told just to enter the information into her chart and did not follow up. On 8/16/24 I got an email telling me that (V4) had stepped down from the position of wound nurse. On 8/19/24, I was told that I was put back in

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charge of wounds. I just never followed up on her foot pressure ulcer." V3 further stated that R3 did see ID (Infectious Disease) doctor last Tuesday (8/27/24) for her pressure ulcer and then she went to Plastics for a debridement the same day.

On 9/5/24 at 2:00 PM, V2 and V11 Director of Clinical Operations both stated that all wounds should be charted on and measured when they are found and both R2 and R3 should have pressure relieving devices on their feet. V11 stated that CNAs should not be doing any treatment to the pressure ulcers. They should only let the nurse know that a dressing is off, or it needs to be replaced.

R3's Admission Profile, print date of 9/3/24, documents that R3 was admitted on 4/24/24 with diagnoses of paralytic syndrome following a stroke, Chronic Respiratory Failure, Dementia, Tracheostomy Status, and Gastrostomy Status.

R3's Minimum Data Set (MDS), dated 8/6/24, documents that R3 is severely cognitively impaired, is dependent on staff for mobility and activities of daily living, has an indwelling urinary catheter, and is always incontinent of bowel.

R3's Care Plan, dated 5/13/24, documents, "(R3) has an unstageable pressure ulcer to left buttock. I require assistance with turning and repositioning. Interventions: 5/13/24 Monitor for pain indicators. 5/13/24 Check dressing placement q (every) shift. 5/13/24 Low Air Loss Mattress. 5/13/24 Monitor for s/s (signs and symptoms) of infection daily increased warmth of surrounding tissue, redness, swelling, pain, purulent drainage, foul odor. Notify MD if identified. 5/13/24 Notify MD as needed if ulcer fails to show progress in healing. 5/13/24 Pain

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medication prior to wound care if indicated. 5/13/24 Provide offloading of ulcer site. 5/13/24 Daily skin checks."

R3's Order Summary Report, dated 9/3/24, documents, "Cleanse coccyx wound with soap and water daily. Apply wet to moist dressing with normal saline to wound bed, cover with ABD (abdominal) pad, and secure with tape BID (twice a day) and PRN (as needed). two times a day. Start date of 8/27/24. Vancomycin HCl Intravenous Solution (Vancomycin HCl) Use 1 gram intravenously one time a day related to OTHER ACUTE OSTEOMYELITIS Start date of 8/20/24. Monitor reddened, blanchable area to left medial foot, daily until resolved in the evening. Start date of 6/1/24. Monitor redness to left great outer toe daily, until resolved in the evening for Redness. Start date of 6/1/24. Skin prep to area on left medial foot, daily, in the evening for DTI (deep tissue injury) area. Start date of 6/1/24."

R3's Wound Doctor Wound Assessment and Plan, dated 7/29/24, documents that R3 has a Left Buttock Unstageable Pressure Ulcer, that is declining with an onset date of 5/13/24, that measures 5.5 cm x 8 cm x a depth that is unable to be determined. The wound bed is 5% granulation, 80% slough, and 15% eschar with serosanguineous drainage.

R3's Wound Doctor Wound Assessment and Plan, dated 8/5/24, documents that R3 has a Left Buttock Unstageable Pressure Ulcer, that is declining with an onset date of 5/13/24, that measures 10 cm x 8 cm x a depth that is unable to be determined. The wound bed is 85% slough, and 15% eschar with a large amount of serosanguineous drainage. This Assessment also documents, "Initially started as wound on patients'

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buttock, but mostly involving the coccyx - rapid onset of this. Irregular / butterfly shape."

R3's Wound Doctor Wound Assessment and Plan, dated 8/12/24, documents that R3 has a Left Buttock Unstageable Pressure Ulcer, that is declining with an onset date of 5/13/24, that measures 6.5 cm x 9.5 cm x a depth that is unable to be determined. The wound bed is 85% slough, and 15% eschar. The wound bed is showing signs of infection with a large amount of exudate which has an odor. This Assessment also documents, "Comments: Ordering wound culture, along with x-ray of sacrum / coccyx."

R3's Wound culture, collection date of 8/13/24, documents,"Org (organism) 1: E. (Escherichia) coli ESBL (extended spectrum beat lactase). Org 2: Proteus mirabilis. Org 3: MRSA (Methicillin resistant Staphylococcus aureus)."

R3's Skin Inspection Assessment, dated 8/13/24, documents that R3 has a Stage 3 pressure ulcer on her left great toe. This Skin Inspection fails to document the size or appearance of the Stage 3 Pressure ulcer.

R3's Radiology Report, dated 8/14/24, documents, "MRI (magnetic resonance imaging) left hip, MRI of pelvis, and MRI right hip. Impression: Large sacral decubitus ulcer extending down to bone with small focus of increased signal and enhancement involving the S6 segment. Findings may represent acute osteomyelitis. 6.5 x 7 cm region of nonenhancing soft tissue overlying the sacrum may represent nonviable tissue with surrounding cellulitis."

R3's Wound Doctor Wound Assessment and Plan, dated 8/19/24, documents that R3 has a

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Left Buttock Unstageable Pressure Ulcer, that is stable with an onset date of 5/13/24, that measures 6.5 cm x 9.5 cm x a depth that is unable to be determined. The wound bed is 10% Granulation / 80% slough, and 10% eschar with undermining at 11 to 1 o'clock 2 cm. The wound bed is showing signs of infection with a large amount of exudate which has an odor. This Assessment also documents, " Comments: X-ray of sacrum / coccyx ordered last week showed findings concerning for acute osteomyelitis of distal sacrum and coccyx. PCP (Primary care Provider) ordered MRI, which reportedly showed evidence of acute osteomyelitis. Has plans to establish with infectious disease next week." It continues: Wound healing / course likely complicated by frequency / completion of dressing changes as well."

R3's Wound Doctor Wound Assessment and Plan, dated 8/26/24, documents that R3 has a Left Buttock Unstageable Pressure Ulcer, that is stable with an onset date of 5/13/24, that measures 7 cm x 9 cm x a depth that is unable to be determined. The wound bed is 20% Granulation, 80% slough, with undermining at 11 to 1 o'clock 2 cm. The peri wound is macerated and there is a large amount of exudate. This Assessment also documents, " Comments: MRI showed evidence of acute osteomyelitis. Currently on IV antibiotics per ID."

R3's Infectious Disease Report, dated 8/27/24, documents, "Assessment: 1. Pressure ulcer, buttock 2. Sacral Osteomyelitis 4. Chronic wound. Plan consult: 80 year old female who presents to (hospital) infectious disease clinic for further evaluation and management of concerns for new onset acute osteomyelitis to a chronic sacral wound as well as ESBL E coli urinary tract

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infection (UTI) with a (indwelling catheter) in place." It continues, " Plan: we will refer to plastics as able to evaluate the patient today for possible debridement of the area." It continues, "for now we will continue broad spectrum antibiotics therapy."

R3's Plastic Surgeon Report, dated 8/27/24, documents, "History of present Illness: This is an 80 year old female presenting with stage 4 sacral pressure sore with underlying osteomyelitis demonstrated on MRI presenting to establish care." It continues, "Skin: Stage 4 sacral pressure sore with exposed bone and fibrinous debris along the lateral aspect encompassing approximately 25% of the wound. Wound measures approximately 6.5 x 5.5 x 3.5 cm. Procedure: Given the extensive fibrinous debris within the stage 4 sacral pressure sore and necrotic tissue burden was recommended that the patient undergo sharp excisional debridement of the fibrinous debris. An Iris scissor and pickups were then utilized to debride skin and subcutaneous tissue from the sacral pressure sore. Total area of debridement was approximately 3.5 x 2 x 2 cm."

R3's Wound Evaluation, dated 9/4/24, documents, R3 has a Stage 3 Pressure Ulcer to the coccyx measuring 4.82 cm x 4.13 cm no depth noted.

R3's Wound Evaluation, dated 9/4/24, documents that R3 has a Pressure Ulcer Stage 1 to the left dorsum (top) 1st digit (hallux), measuring 0.67 cm x .48 cm, and the wound bed is scabbed.

R3's Electronic Medical Record (EMR) fails to document a full assessment or treatment for R3's left medial Great toe pressure ulcer before

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9/3/24.

R3's EMR fails to document a full assessment for R3's left medial foot.

R3's Health Status Note, dated 9/4/24 at 11:00 AM, documents, "This writer drew blood from midline to Rt (right) upper arm for labs that were ordered. Resident laying in bed, s(sic) labored and uneven, resident felt warm, tympanic temperature 101.9. Staff nurse reported that resident had large amount of green/gray sputum earlier this AM. Blood obtained for labs. Reviewed resident with IDT (Interdisciplinary) members."

R3's Health Status Note, dated 9/4/24 at 11:14 AM, documents, "Call placed to (V13 R3's Power of Attorney (POA)). Updated on elevated temp (temperature) and copious amounts of thick green/gray sputum. Updated (V13) of nursing judgement to be sent to ER (Emergency Room) for evaluation and treatment. (V13) in agreement."

R3's Health Status Note, dated 9/4/24 at 5:19 PM, documents, "This writer called for an update on resident. She has sepsis that they believe is from her wound. She has a UTI, but they do not believe that it is bad enough to cause sepsis. Her temperature is down, and she is waiting on placement at a higher acute care hospital."

R3's Health Status Note, dated 9/11/24, documents, "Resident arrived back to facility at 330p per our transport."

R3's Hospital Discharge Summary, dated 9/11/24, documents, "I was in the hospital because: I was unresponsive with fevers. The medical term for this is: Sepsis, osteomyelitis."

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On 9/16/24 at 12:30 PM, V2, was questioned as to why the observation of R3's sacrum pressure ulcer size on 9/3/24 was so different than the measurements documented on the Wound Evaluation of 9/4/24, V2 stated our pressure ulcer documentation is that the nurse will put a sticker near the ulcer and then take a picture. The system then does all the measurements, so the nurses do not do any measuring it is all calculated in the computer system. V2 further stated that every pressure ulcer should be measured and described when found and then again weekly.

On 9/17/24 at 11:55 AM, V4, Wound Nurse, was questioned why R3 did not have an assessment for her left medial foot pressure ulcer, V4 stated that she did not realize that she did not and that she would put one in. V4 stated that the left medial foot pressure ulcers should have been identified and treated sooner. V4 stated that R3 should have had pressure reducing foot boots on. V4 also stated that she is still learning the computer system for wounds and how to get the camera to take good measurements. V4 did agree that what you see is not what is being charted because of the computer system. V4 was questioned about R3's sacral pressure ulcer and it's decline, V4 stated that she believes she has so many bodily fluids that would contaminate the dressing and the wound and R3 was just not cleaned up timely or the dressing changed timely, and the infection set in, and the pressure ulcer deteriorated.

2. R2's Transfer Discharge Report, print date of 9/3/24, documents that R2 was admitted on 2/4/21 with diagnoses of Heart Failure, Parkinson's Disease, and Dementia.

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(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
S9999	Continued From page 12	S9999		

R2's MDS, dated 7/1/24, documents that R2 is severely cognitively impaired and requires moderate assistance for transfers.

R2's Skin Inspection Assessment, dated 8/14/24, documents that R3 has an In House Acquired Left Heel Stage 3 Pressure Ulcer which measures 1.6 cm x 1.3 cm. This assessment fails to document appearance of the pressure ulcer.

R2's Health Status Note, dated 8/15/2024 12:15, documents, "Note Text: vm (voicemail) left to update POA on wounds to L (left) heel stage 3, abrasion to right toe and sacrum - unstageable noted during wound rounds yesterday. POC (plan of care) ONGOING MD (Medical Doctor) short form filled out for review. will continue current treatments as advised pending MD response."

R2's Skin & Wound Evaluation V7.0, dated 8/21/24, documents that R2 has an In house Acquired Stage 3 Pressure Ulcer measuring 1.2 cm x 1.7 cm x 0.1 cm to the left heel, has serosanguineous drainage, and was discovered on 8/13/24.

R2's Physician Order, dated 8/22/24, documents, "Cleanse wound to left heel with normal saline. Apply calcium alginate to wound bed. Cover with dry dressing daily and PRN."

R2's Physician Order, dated 8/30/24, documents, "Float heels every shift for wound care Encourage resident to float heels as often as resident will allow."

R2's Treatment Administration Record, dated 9/2024, documents, "Cleanse wound to left heel with normal saline. Apply calcium alginate to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000723	A. BUILDING: ______ B. WING ______	C 09/17/2024

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wound bed. Cover with dry dressing daily and PRN. Start date of 8/22/24." R3's EMR fails to document any treatment orders for R3's heel before 8/22/24.

R2's Skin & Wound Evaluation V7.0, dated 9/3/24, documents that R2 has a In house Acquired Stage 3 Pressure Ulcer measuring 1.5 cm x 1.3 cm x 0.1 cm to the left heel.

R2's EMR fails to document any assessment of the left heel pressure ulcer before 8/21/24 and between 8/21/24 and 9/3/24.

On 9/3/24 at 8:51 AM, R2 is sleeping in her bed. R2 has her left foot hanging of the side of the bed. R2 is not wearing any pressure relieving boots on her feet.

On 9/3/24 at 10:05 AM, V4, Wound Nurse, stated that R2 has a blister on her left heel that is getting skin prep to it. R2 is sitting up in her wheelchair. R2 is wearing gripper socks. V4 removed her sock and examined the left heel. The left heel did not have a dressing on it. V4 stated that it is not a blister anymore and she needs to go and reread the treatment orders. R2's left heel has a pressure ulcer approximately the size of a quarter, the wound bed is brown in color, and the periwound is red. V4 returns to the room and stated that the area is cleansed with wound cleanser, calcium alginate applied to the wound bed, and covered with a dressing. V4 performed the treatment with no concerns. V4 placed R2's gripper socks back on her.

On 9/3/24 at 3:40 PM, V3, LPN/MDS, stated that a team from the sister facility came in to do a house wide sweep of resident's skin, and also identified the pressure ulcer on R2's foot. V3

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stated that R2 does not see the wound clinic and that her primary physician ordered the treatment for her pressure ulcer.

On 9/3/24 at 4:00 PM, R2 was observed sitting in her wheelchair with no pressure relieving boots on.

On 9/17/24 at 11:55 AM, V4, Wound Nurse, was questioned why R2 did not have a pressure reducing device on her left foot, V4 stated that the supply company does not like to use the heel boots, but they like to use a foot elevator which is an elevated surface that sits at the end of the bed and the foot rest's on it while the resident is in bed. V4 was questioned what is done during the day since she sits in the wheelchair most of the day, V4 stated, "Your right. I didn't think about that."

The policy Pressure Ulcer Prevention, Identification & Treatment, dated 10/16/23, documents, "Procedure: 3. When a pressure ulcer is identified whether in-house, or upon a resident's admission, the area will be assessed using the Skin & Wound assessment and initial treatment started per physician's orders. 4. The physician is to be notified when A) pressure ulcer develops, B) when there is a noted lack of improvement after a reasonable amount of time, C) and / or signs of deterioration. 5. If Pressure Ulcer is found initiate a treatment sheet and complete the skin inspections assessment in PCC (Point Click Care (computer program)." It continues, "Documentation of the pressure ulcer must occur upon identification and at least once a week until healed. Assessment is to include: a. Characteristics: (i.e. (for example)) size, depth, color, drainage) b. presence of granulation tissue, necrotic tissue. c. Treatment and response to

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S9999	Continued From page 15 treatment. d. Prevention technique (i.e. turning and positioning, skin care, protective devices) e. Update MD and resident / POA of any regression in wound." (A)	S9999		