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	IL6008163	A. BUILDING: _____ B. WING _____	07/12/2024

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Findings 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)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 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	S9999		

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S9999	Continued From page 1 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: 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.	S9999		

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These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify areas of pressure for 2 of 3 residents (R45, R56) reviewed for pressure in the sample of 24.

This failure resulted in R45 developing two stage 4 pressure injuries, one on each heel, requiring surgical debridement to remove non-viable tissue, and R56 developing an unstageable pressure injury to her left hip requiring debridement.

The findings include:

1. R45's Admission Record, provided by the facility on 7/11/24, showed she had diagnoses including a stage 4 pressure ulcer of right heel, and a stage 4 pressure ulcer of left heel, protein-calorie malnutrition, acute embolism, and thrombosis of unspecified deep veins of left lower extremity, and bilateral primary osteoarthritis of knees. R45's 6/10/24 facility assessment showed R45 had severe cognitive impairment, required substantial/maximal assistance from staff for toileting, personal hygiene, upper and lower body dressing, rolling side-to-side in bed, and transfers. R45's care plan initiated on 5/1/24, showed she had the potential for impaired skin integrity as evidenced by Braden Scale for Predicting Pressure Ulcer Risk. High risk for pressure ulcer. The care plan showed "Evaluate skin integrity...Provide skin care per facility guidelines and as needed."

On 7/11/24 at 9:24 AM, V11 (Wound Nurse/LPN) performed a dressing change to the wounds on R45's bilateral heels. V11 stated he thinks the wounds on R45's heels were there for a while before he noticed them and did his assessment.

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V11 stated no one notified him of the wounds. V11 stated R45 has MRSA (Methicillin-resistant Staphylococcus aureus-an infection that's become resistant to many of the antibiotics used to treat ordinary staph infections) in her wounds and was currently receiving antibiotics. The wound on R45's right heel was about the size of a dime. The border of the wound had white, moist tissue all around the edge of the wound bed. V11 cleaned the wound with normal saline-soaked gauze, dried the area, and applied an ointment used to remove damaged tissue from the wound bed. V11 applied calcium alginate dressing (a dressing that can absorb excess moisture and promote wound healing) to the wound, then covered the wound with foam dressing and wrapped R45's heel and foot with kerlix gauze. V11 removed the dressing from R45's left heel. R45's left heel was at least twice the size of the right heel. The wound bed was not as red/beefy looking like the right heel. V11 cleansed R45's left heel wound and applied the same treatment as the right heel. At 11:54 AM, V11 said both of R45's heel wounds were identified at the same time. V11 stated he thinks he saw R45's skin sheet and it showed something on her heels, so he checked her heels and saw the open areas. At 12:07 PM, V11 stated he would expect staff to identify an area of skin concern prior to it becoming a stage IV pressure ulcer and report it to him right away so he could assess it and start interventions. V11 stated no staff reported it to him. he saw the skin sheet in his mailbox on 6/4/24 and assessed her. When asked about his initial assessment identifying R45's wounds as unstageable. V11 stated he does not stage the wound; he lets the wound doctor/nurse practitioner stage the wounds. V11 provided surveyor with R45's skin sheet dated 6/3/24 showing both heels circled. The skin sheet

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showed "Open Wound." V11 was asked to provide skin sheets for R45 prior to the 6/3/24 skin sheet. No additional skin sheets were provided prior to exiting the facility.

R45's Wound Observation Tool, electronically signed by V11 on 6/5/24, showed a facility acquired unstageable pressure area to her left heel effective as of 6/3/24 measuring 2.2 cm (centimeters) long x 2.5 cm wide x 0.1 cm depth. Infection suspected. Moderate serous drainage, odor, and inflammation/induration (localized hardening of soft body tissue) present.

R45's Wound Observation Tool, electronically signed by V11 on 6/5/24, showed a facility acquired unstageable pressure area to her right heel effective as of 6/3/24 measuring 2.7 cm in length x 4.0 cm in width x 0.1 cm in depth. Infection suspected. Moderate serous drainage, odor, and inflammation/induration present.

R45's 6/7/24 Initial Wound Evaluation and Management Summary performed by V13 (facility contracted Wound Doctor) showed a stage 4 pressure wound of the right heel measuring 2.3 cm x 2.2 cm x 0.1 cm. The evaluation also showed a stage 4 pressure wound of the left heel measuring 3.0 cm x 4.0 cm. The evaluation showed the depth of the wound was not measurable due to presence of nonviable tissue and necrosis (thick adherent black non-viable skin tissue). The evaluation showed 100% necrotic tissue (eschar). A surgical debridement procedure was performed to remove the thick adherent eschar and devitalized tissue, establish the margins of viable tissue, and remove infected tissue. V13's procedure note showed surgical excision of devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.3 cm

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to R45's left heel. The evaluation also showed a deep wound culture of the stage 4 pressure wound on R45's left heel was recommended by V13 on 6/7/24.

R45's 7/9/24 Wound Evaluation and Management Summary by V13 showed the pressure wound to her left heel measured 2.5 cm x 2.3 cm x 0.2 cm, and the pressure wound to her right heel measured 0.9 cm x 0.8 cm x 0.2 cm. The evaluation showed MRSA positive wound culture to R45's right heel. The evaluation also showed "X-Ray pending on pressure wound of the heel as of 7/9/24."

The Radiology Results Report dated 7/9/24 showed X-rays were performed on R45's left and right heels. The results showed no osteomyelitis (inflammation of the bone caused by infection spreading from nearby tissue) was seen.

On 7/11/24 at 12:56 PM, V2 (Director of Nursing) stated the CNAs (Certified Nursing Assistants) usually alert first regarding skin concerns and put the information on the resident's shower sheet. V2 stated the CNAs have to report the concern to her. She (V2) lets V11 (Wound Nurse) know, and he will do an assessment. V2 stated she would expect the nurses and the CNAs to identify an area of skin concern, prior to it becoming a stage 4 that looked infected. V2 added, "Clearly there would have been something there prior."

On 7/12/24 at 8:59AM, V18 (Nurse Practitioner) stated, "(R45) is definitely at increased risk for pressure ulcers with all of her comorbidities. She is dependent on the staff for her cares and repositioning so this should have been caught way sooner. I got a call from an agency nurse that they found pressure ulcers and I just couldn't

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believe it. I feel bad because I thought we were on top of her care and obviously the skin checks weren't being done otherwise we would have caught it sooner. It is unacceptable to find a wound when it is at a stage 4. At this point, we are back-peddling and trying to play catch-up with her wound care to try and heal it because it is more advanced. When you catch a wound in its earlier stages it is much easier and quicker to heal but now this will take some time and diligence with wound care. Weekly skin checks should be done on all residents that are at high risk for skin breakdown and these 2 residents are high risk residents. (R56) already has a surgical wound on her right hip and now we have to try and heal her left hip pressure ulcer. It makes me sad that these 2 residents are going through this because I thought we were really on top of their care. Both of these wounds should have been identified sooner and I believe they would have been if we were doing the weekly skin checks and observing their skin more closely during daily cares."

R45's June 2024 Medication Administration Record (MAR) showed she was started on Keflex 500 mg (milligrams) every 12 hours for 10 days on 6/4/24, for prophylaxis for wound infection. The June MAR showed that order was discontinued, and she was started on Bactrim DS 800-160 mg twice daily on 6/11/24 through 6/21/24 for MRSA in wound.

R45's June 2024 Treatment Administration Record showed an order on 6/3/24 to apply santyl (a debridement ointment) and cover with a dressing to bilateral heels. The TAR showed on 6/5/24 orders were changed to Cleanse with normal saline, pat dry, apply Santyl, apply alginate calcium once daily and as needed.

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Gauze island with border dressing, apply once daily and as needed for right and left heels.

The facility's February 2023 policy and procedure titled Skin Audits by Nursing Assistants showed It is the facility's policy to communicate changes in skin condition to appropriate personnel as part of their systematic approach for pressure injury prevention and management. "1. Nursing assistants shall inspect all skin surfaces during bath/shower and report any concerns to the resident's nurse immediately after the task. 2. Nursing assistants shall also report changes in skin condition that are noted during any care procedure. 3. Skin conditions that shall be reported include but are not limited to: a. Redness b. Bruising c. Swelling d. Rashes, hives e. Blisters (clear or blood-filled) f. Skin tears g. Open areas, ulcers, lesions."

2) R56's electronic face sheet printed on 7/11/24 showed R56 has diagnoses including but not limited to dementia with behaviors, sciatica, bipolar disorder, osteoarthritis, pressure ulcer of left hip-unstageable, and non-pressure chronic ulcer of left buttock.

R56's facility assessment dated 5/16/24 showed R56 has no cognitive impairment and has no pressure injuries.

R56's care plan dated 6/19/24 showed, "The resident has pressure ulcer or potential for pressure ulcer development related I have 2 wounds and am being seen by the wound doctor/nurse. (SITE 6) unstageable (due to necrosis) of the left hip. 6/21/24 this is now a stage 4...Follow facility policies/protocols for the prevention/treatment of skin breakdown. Monitor/document/report PRN (as needed) any

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changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage...."

R56's physician's orders for May 2024 showed no orders for R56 to have weekly skin assessments.

R56's May 2024 skin checks showed R56 had 1 skin check for the month of May on 5/30/24 (the same day R56's unstageable wound was identified).

R56's wound assessment dated 5/31/24 showed, "Unstageable left hip pressure ulcer. 100% thick adherent black necrotic tissue. 2.5x3.6 cm (centimeters)."

R56's wound assessment dated 6/21/24 showed, "Stage 4 left hip pressure ulcer 2.9 x 1.3 x 0.2 cm... moderate serous exudate (clear drainage) Surgical Excision Debridement Procedure: Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis prior to this point. This wound has now revealed itself to be a Stage 4 pressure injury."

On 7/11/24 at 2:08PM, V11 (wound care nurse) stated, "(R56's) pressure ulcer started as a blister that was not opened. I can't say how it developed but we applied a foam dressing until the wound care nurse practitioner could evaluate it on 5/31/24. The wound care physician debrided it and found it to be a stage 4 pressure ulcer. I was notified by the nursing staff on 5/30/24 that she had the blister, so I went down and assessed it and notified the wound care nurse practitioner and she came and saw her on 5/31/24. The only weekly assessments I have is the one I gave you

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for 5/30/24. The staff should have been doing weekly skin assessments on (R56) due to her high risk for skin breakdown and existing surgical wound on her other hip. I can't say why they didn't do the weekly assessments but perhaps we could have caught this before it developed into an unstageable wound and had to be debrided."

The facility's policy titled, "Pressure Injury Prevention and Management" dated February 2023 showed, "This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries...c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record...e. nursing assistants will inspect the skin during bath and will report any concerns to the resident's nurse immediately after the task..."

(A)
Statement of Licensure Violations 2 of 2:
300.610a)
300.1010h)
300.1210b)
300.1210d)2)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

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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.

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.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to perform weekly

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weights as ordered by a physician for 1 of 7 residents (R58) reviewed for nutrition in the sample of 24.

This failure resulted in R58 experiencing a significant weight loss of 7.96% within a 3-month period before it was identified by facility staff and R58 was referred to the facility dietician.

The findings include:
R58's electronic face sheet printed on 7/11/24 showed R58 has diagnoses including but not limited to traumatic subdural hemorrhage, type 2 diabetes, unspecified protein-calorie nutrition, anemia, and history of pneumonia.

R58's facility assessment dated 5/20/24 showed R58 has severe cognitive impairment and has weight loss of 5% or more in the last month or 10% or more in the last 6 months.

R58's care plan contained no problems or interventions for R58's weight loss.

R58's physician's orders dated 8/24/23 showed, "Weight every day shift every Thursday."

R58's medication administration record (MAR) for April 2024 showed R58 weighed 120.6lbs on 4/19/24. No weight was obtained for R58 the following week on 4/25/24.

R58's MAR for May 2024 showed no weight was obtained for R58 on 5/2/24. 3 weeks passed without weekly weights being obtained for R58. On 5/9/24, R58 weighed 114lbs. This was a 5.47% weight loss within less than one month.

R58's weight as of 7/6/24 was 111lbs which is an additional 3lb weight loss since May 2024.

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R58's dietician assessment dated 5/27/24 showed, "Weight 5/6/24 114lbs. comparative weight loss 10.5% within 6 months.... Weight no lower desired."

On 7/11/24 at 1:54PM, V2 (Director of Nursing) stated, "The dietician is here at least once a week. I believe she is seeing (R58). We have a risk meeting every week and review all of the weekly weights and any concerns. For this week, (R58) is not on the list that the dietician reviewed. I can see where this is an issue. Staff should have been documenting the weights and obtaining them as ordered. (V17-lead certified nursing assistant) is the one who puts the weight list out for the aides on the floor, so they know who needs to be weighed." V17 then entered the room for the interview and stated she was unaware that R58 needed to be a weekly weight and she has not been notifying staff to weigh her weekly; therefore, there are no weekly weights being done for R58.

On 7/11/24 at 2:38PM, V13 (Dietician) stated, "I go through the weights each month and look at who needs to be assessed by me. (R58's) nurse practitioner wanted me to see her and have weekly weights done on her because she has lost more weight. I haven't followed up on the last weight they were supposed to do earlier this week. (R58 had no weekly weight done as of 7/11/24). In May she was on my list, so I added a supplement for her. If she triggers on the weight change or MDS (minimum data set) then I would see her. Whatever comes up on the weights and exception report on (computer system) is who I see, and I don't recall her being on that. Obviously if there were weights ordered weekly that's what they should have been doing so we

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	IL6008163	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF ZION	3615 16TH STREET ZION, IL 60099

(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 13	S9999		

could have maybe caught this prior to it becoming significant. I suppose she wouldn't show up on the weight report if they aren't doing the weights and entering them so that is also a problem."

The facility's policy titled, "Weight Monitoring" dated February 2023 showed, "Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise...Weight can be a useful indicator of nutritional status. Significant unintended changes in weight or insidious weight loss may indicate a nutritional problem...4. Interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status...5. A weight monitoring schedule will be developed upon admission for all residents: c. residents with weight loss-monitor weight weekly."

(B)