STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008817	A. BUILDING: ____ B. WING ____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION SAINT ANNE PLACE	**4405 HIGHCREST ROAD ROCKFORD, IL 61107**

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1210 d)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	S9999		

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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

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.

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.

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These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess and notify the wound care physician with changes in a pressure injury, and failed to implement pressure relieving intervention to prevent a pressure injury. This applies to 2 of 8 residents (R95 & R100) reviewed for pressure injuries in the sample of 23. These failures resulted in R100's pressure injury deteriorating to an unstageable pressure injury.

The findings include:

1. R100's face sheet lists his diagnoses to include: nondisplaced intertrochanter fracture (hip fracture), type I diabetes mellitus, and coronary heart disease.

R100's wound assessment report, dated 7/3/24 shows a newly identified stage 1 pressure ulcer was found on his right heel. The pressure ulcer measured 7.00 cm (centimeters) X 5.00 cm.

R100's care plan, with problem onset of 7/10/24, shows, "Problem/Need: Pressure ulcer stage 2 to right bottom heel. Approaches: Measure wound at least weekly. Record HxWxL (height x width x length), appearance, amount and odor of any drainage. Report any decline in would status to physician."

R100's local hospital vascular surgery progress notes, dated 7/22/24 show, "This is a 83-year-old gentleman who has a history of insulin dependent diabetes. Most recent A1C (blood check for insulin) from April of 2024 A1C 7.7. He has been following with podiatry for tissue loss. He unfortunately had a left hip fracture and was

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admitted to rehab.... From the standpoint of his lower extremity vasculature he has normal toe pressures bilaterally. On the left his ABI (ankle brachial index) is likely falsely elevated secondary to medical calcinosis with the waveform morphology demonstrates small T-wave phasic waveform. On physical exam he has clearly audible posterior tibial signal. From the standpoint of his lower extremity aterial perfusion I do believe with his toe pressure within normal limits he has enough perfusion to heal this superficial wound to the posterior heel.... We would recommend continued local wound care either with the podiatry clinic or with the wound care center."

R100's wound assessment report dated 7/30/24 shows the same pressure ulcer was now a stage 2 measuring 3.00 cm X 3.00 cm with 5% slough and 95% granulation. "Stage 2 pressure ulcer to bottom of right heel/foot assessed. Wound continues improving..."

On 8/7/24 at 9:05 AM, V4, Wound Care Nurse (WCN), stated R100 had a pressure ulcer on his heel that was healing. She sees him weekly to do assessments, otherwise, the floor nurses do the dressing changes daily. R100 had gone to a vascular appointment on 7/22/24 that was previously scheduled prior to admit to the facility. At that appointment, they did a doppler to check the pressures in his legs. They did not find anything significant and referred him to a wound care doctor to follow for his pressure ulcer. She stated he has not seen any wound care doctors yet and does not have any appointments set up.

On 8/7/24 at 10:00 AM, R100 was lying in bed. He had a quarter size black soft circular wound to his right heel. He winced in pain when V4, WCN

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(Wound Care Nurse), removed the dressing and pressed in the middle of the wound. He stated the wound hurt and was painful. At 10:40 AM, V4, WCN, stated, "The wound has deteriorated in one week since I last saw it. Now it has eschar (dead tissue). I would expect the floor nurses to notify me and the doctor of any changes in the wound." She had not heard anything about any changes in the wound.

On 8/7/24 at 10:35 AM, V11, Wound Care Doctor, stated, "If the wound is soft ("boggy") as being described, I would call it an unstageable necrosis. I would expect the facility to manage a stage 1 or 2 pressure injury, but beyond that they should be consulting with someone with experience (him or an outside wound care clinic)."

The facility's Procedure: Pressure injury assessment/treatment, dated July 2024, shows, "Purpose: The purpose of this procedure is to provide guidelines for a consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and the prevention of acquiring additional pressure injuries.... Definitions and descriptions: B. Pressure injury: A localized injury to the skin and/or underlying tissues as a result of pressure or pressure in combination with shear/friction. Pressure injuries usually occur over a bony prominence and are staged to classify the degree of damage. I. Eschar tissue: Dead or devitalized tissue that is hard or soft in texture; usually black, brown or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.... Stage 2 Pressure injury: Partial-thickness loss of skin with exposed

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dermis. The wound bed is pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible, Granulation tissue, slough and eschar are not present.... Unstageable: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) in the wound bed."

2. R95's Physician Orders Summary for August 2024 shows an order, with a start date of 1/23/24, for oxygen at 2-4 liters continuous, and an order with a start date of 2/24/24, for (ear protectors) applied to oxygen tubing at all times.

R95's current Care Plan shows he has a self care deficit and requires extensive staff assistance for his Activities of Daily Living due to weakness. The Care Plan also shows on 7/17/24 he was found to have stage 2 pressure ulcer behind his right ear.

A Wound Assessment Report completed on 7/17/24 shows R95 has a new facility acquired stage 2 pressure ulcer measuring .30 cm long, X .30 cm wide, X .20 cm deep with a scant (small) amount of serous (clear) drainage.

A Braden Risk Assessment reported, completed 7/17/24, shows R95 is at high risk to develop a pressure injury.

On 8/5/24, at 10:30 AM, R95 was lying in bed with his wife at his bedside. R95 had oxygen running via a nasal cannula tubing which was behind both ears. Behind and under his right ear were some gauze bandages, and behind his left ear wrapped around the tubing was a Styrofoam circular tube.

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On 8/6/24 at 11:42 AM, V7 (R95's spouse) said, "He (R95) has been on oxygen continuously since he has been at the facility and he has a sore behind his ear from the oxygen tubing. The grips they use on the tubing are useless, they slide around all the time and fall off when staff reposition him. I come to the facility every day and sometimes the grips are just lying on his bedside table and not even on the tubing."

On 8/6/24 at 1:02 PM, V4 (Wound nurse) said the oxygen tubing around R95's ear caused a stage 2 pressure injury. V4 said they use (ear protectors--grips like a foam pool noodle) to try to prevent it, but they are not effective they don't stay in place and they pop off the tubing from him moving.

On 8/7/24 at 9:16 AM, V6 (Regsitered Nurse/RN) said R95's tube grips fall off and slide around. He said he is unaware of any other interventions that were tried to prevent the pressure injury. V6 said the staff do not do daily checks behind the ears of residents on oxygen; they check when a resident is bathed, or once a week on skin check days and oxygen tubing change days.

The facility provided Pressure Injury Assessment/Treatment policy, revised 7/2024, shows pressure relieving devices should be observed for effectiveness and interventions changed or implemented to prevent the development of pressure injuries

(B)