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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)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	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. (B)

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 develop pressure sores unless the individual's clinical condition demonstrates that the pressure

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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 observation, interview and record review, the facility failed to implement necessary treatment and services consistent with professional standards of practice to promote healing and prevent new ulcers from developing for a resident identified at risk. The facility failed to:
1. Failed to initial or sign on the electronic treatment administration record (eTAR) after each treatment for 3 (R1, R4 and R5) residents with pressure ulcers.
2. Failed to revise care plan to reflect alteration of skin integrity, approaches, and goals for care for 1 (R5) resident with multiple facility acquired pressure ulcers.
3. Failed to do weekly wound assessment for 3 (R1, R4 and R5) residents with pressure ulcers.
4. Failed to complete Braden scale assessment upon admission for a total of four consecutive weeks for 1 (R1) resident with multiple pressure ulcers.
5. Failed to complete nutritional consultation or assessment for 1 (R1) resident with multiple pressure ulcers.
6. Failed to ensure treatment orders for 1 (R5) resident with multiple facility acquired pressure wounds.
7. Failed to monitor wound dressing to ensure it was intact and adhering for 1 (R4) resident with pressure ulcer.
These failures affected 3 (R1, R4 and R5) out of 3 residents reviewed for pressure ulcers. R1 with 2 stage 3 pressure ulcers to left elbow and

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coccyx, R4 with Stage IV pressure ulcer to sacrum, and R5 with multiple facility acquired Stage III pressure ulcers to left posterior thigh, right heel, right and left ischium.

The findings include:

R1's health record documented admission date on 1/8/24 with diagnoses not limited to Encounter for orthopedic aftercare following surgical amputation, Muscle wasting and atrophy, Dysphagia oropharyngeal phase, Type 2 diabetes mellitus with other circulatory complications, Acquired absence of left leg below knee, Peripheral vascular disease, Sepsis, Unspecified personality and behavioral disorder due to known physiological condition, Depression, Schizophrenia, Acquired absence of right leg below knee, Other polyosteoarthritis, Gastro-esophageal reflux disease without esophagitis, Anemia. R1's health record showed discharge date on 1/27/24.

R4's health record documented initial admission date on 2/11/22 with diagnoses not limited to Other chronic osteomyelitis, right ankle and foot, Methicillin resistant staphylococcus aureus infection, Local infection of the skin and subcutaneous tissue, Gangrene, Non-pressure chronic ulcer of other part of left foot with necrosis of bone, Pressure ulcer of sacral region stage 4, Peripheral vascular disease, Hypertensive heart disease with heart failure, Opioid use, Burn of third degree of left foot, Burn of third degree of right foot, Resistance to vancomycin vre of the wound, Insomnia, Cocaine use, Anemia, Major depressive disorder, recurrent, Heart failure, Schizophrenia, Sepsis, Cellulitis of left lower limb, Homelessness unspecified, Primary osteoarthritis.

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R5's health record documented initial admission date on 11/07/14 with diagnoses not limited to Unspecified injury at unspecified level of cervical spinal cord, Paraplegia, Neuromuscular dysfunction of bladder, Type 2 diabetes mellitus with unspecified complications, Pressure ulcer of other site, stage 3 (left posterior thigh left ischial tuberosity right ischium), prostatic hyperplasia without lower urinary tract symptoms, Vitamin d deficiency, Methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere, Peripheral vascular disease, Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, Gout, Essential (primary) hypertension, Chronic kidney disease, Major depressive disorder, Gastro-esophageal reflux disease without esophagitis, Nutritional anemia, Other hereditary and idiopathic neuropathies, Extended spectrum beta lactamase (esbl) resistance.

On 2/14/24 at 10:04am observed R4 lying in bed, alert and verbally responsive, appears comfortable, with air mattress in place. Wound care observation conducted with V4 (Wound Care Director) assisted by V41 (Wound Care Nurse). Observed R4 open his incontinence brief, clean and dry. Observed open wound on sacral area with no dressing in place. V4 stated that maybe the CNA (Certified Nursing Assistant) had removed the dressing during care. V4 stated the sacral wound is classified as Stage IV acquired in the facility. Observed wound bed about 80% pinkish and 20% granulating tissue, no yellow slough noted. Observed V4 cleanse the wound with NSS (normal saline solution) then applied calcium alginate and covered with dry dressing.

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At 10:19am observed R5 lying on bed, alert, and oriented x 3, verbally responsive, air mattress in placed. R5 refused wound care observation. He stated that wound care was already done by staff. R5 agreed wound to be seen by surveyor with V4. Observed V4 opened dressing on left posterior thigh, observed with open wound. V4 stated it is classified as Stage III. Observed wound bed 70% pinkish to reddish and about 30% yellow slough. R5 refused other wounds to be seen by surveyor.

At 10:24am V43 (Certified Nursing Assistant/CNA) said she is assigned to R4, and her shift started at 7:00am. She stated that R4 uses urinal, and she did not change R4 yet and is about to check for incontinence episode. V43 said she did not remove or touch R4's wound dressing on the buttocks.

At 10:48am V44 (Consultant Dietician) stated that residents with pressure wounds have metabolic stress in the body, the body is losing a lot of fluids and proteins, could have muscle wasting, dehydration, at risk for developing more pressure ulcers due to weight loss from the other wounds not healing so nutritional assessment or evaluation is needed. He said that caloric needs changed when there is an existing or non-healing wound. V44 said interventions with additional nutritional supplements or additional protein in the diet is important for wound healing. V44 stated that resident with a pressure ulcer is needing more calories and more protein to create / restore the tissue to promote wound healing. V44 stated that if nutritional supplements were missed or not given this could put resident at risk for weight loss, wound could get worst or could delay wound healing. Reviewed R1's EHR (electronic health record) with V44 and said he tried to see R1 but there was no wound assessment at the time

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when he was in the facility, so R1 was not seen. V44 stated not able to find any nutritional assessment / evaluation documentation in R1's EHR so it was not done.

At 12:58pm Reviewed EHR with V4 (Wound Care Director) for the following residents:
1. R5 - V4 stated he has multiple acquired Stage 3 pressure wounds to right heel, right ischial, left posterior thigh and Left ischium that were not healed and no change in wound status. V4 stated that wound assessments should be done weekly and per EHR wound documentation was done on 12/25/23 then 1/21/24, it does not indicate that it was being done on a weekly basis.
2. R4 - V4 stated that he has an acquired Stage IV pressure wound to sacrum, not healed, no change in wound status.
3. R1 - V4 stated that he was admitted with 2 stage 3 pressure wounds to left elbow and coccyx and surgical wound related to Left AKA. V4 said that she saw wound documentation for R1 on 1/21/24 for coccyx, no wound documentation for left elbow and coccyx upon admission on 1/8/24 and 1/15/24. V4 said Braden scale assessment was done on 1/8/24, no Braden scale assessment done on 1/15/24 and 1/22/24. V4 Stated "I don't know" why Braden scale and wound assessment were not done as she was not doing wounds at that time. She said that she is trying to catch up with assessments. V4 said that skin assessment is done to document any skin breakdown or skin condition upon admission. V4 said that Braden scale is a risk assessment that would include shearing/friction, mobility, and moisture. V4 stated that the wound care team signs the electronic treatment administration record (ETAR) after providing the treatment to resident to make sure that it was done. She said that if ETAR was not signed it means that

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treatment was not provided. V4 said if treatment was not provided or missed, this could potentially lead to wound infection, delay wound healing or worsening of wound. V4 stated that the purpose of wound dressing is to keep the wound from being infected or contaminated. She said that if dressing fell off or was soiled and removed, there is PRN (as needed) order and treatment should be done by floor nurse. V4 said that nutritional supplements are important to build protein that helps in wound healing. V4 stated that wound treatment for R1, R4 and R5 wounds should have an order in the resident's EHR.

At 2:42pm V36 (Assistant Director of Nursing/ADON, RN) said wound dressing should be monitored and should be in place to keep the wound from debris, contamination that could possibly be at risk for infection and could worsen/damage/delay wound healing. V36 said Braden scale is an assessment for friction, mobility, moisture, mobility to predict risk for skin breakdown so it will guide the staff on how many times the resident needs to be changed or needing repositioning. V36 said wound assessment should be done on a weekly basis to assess progress of existing wound, if it is not done weekly, not able to evaluate if the treatment is effective or working or if needs to be changed or additional interventions should be implemented. V36 said nutritional supplements are very important in maintaining proper nutrients in repairing, rebuilding, and restoring skin tissues to aid or help in wound healing. She said TAR/MAR (Treatment Administration Record/Medication Administration Record) should be signed after providing treatment and after medication administration to prove that treatment was provided, and medications/nutritional supplements were given. V36 said if it was not

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signed or not documented, it was not done or was not given. V36 stated that if treatment is missed or not provided, this could lead to wound infection, worsening of the wound or delay wound healing. V36 said if nutritional supplements are not given, this could delay wound healing or worsen the wound. R1's EHR was reviewed with V36, V36 stated that R1 was transferred to hospital on 1/27/24 due to purulent drainage on left AKA (above the knee amputation) and was admitted to hospital with possible wound infection.

At 4:49pm V39 (Wound Nurse Practitioner/NP) stated that he is following R4 and R5 every other week and both residents are at risk for skin breakdown due to contributing factors which are immobility, incontinence, and multiple comorbidities. He said that he was not familiar with R1 and R1 was not seen for wound evaluation. V39 stated that if there is a missed treatment or treatment not done, this could potentially worsen the wound, delay wound healing or could lead to infection. He stated that wound dressing is important to be maintained to prevent wound contamination that could potentially delay wound healing or worsening of wound. V39 stated that nutritional supplements are very important for wound healing, help the body rejuvenate, repair damage tissues and aid in healing process.

On 2/15/24 at 10:52am V40 (Nurse Practitioner/NP) was interviewed via phone and stated that she is familiar with R1, R4 and R5. V40 said if wound treatments were missed or treatments were not done, this could potentially delay wound healing, worsening of the wound or could lead to infection. V40 said that wound dressing should be maintained to prevent

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contamination of the wound that could possibly lead to infection, delay wound healing if wound dressing is not maintained. V40 said nutritional supplements could play a part together with wound healing. She said that if nutritional supplements are not given as ordered could potentially delay wound healing or worsen the wound.

MDS (Minimum Data Set) dated 1/14/2024 showed R1's cognition was moderately impaired. R1 needed set-up/clean-up assistance with eating; Partial/moderate assistance with oral hygiene; Total assistance/Dependent with toileting and personal hygiene, shower/bathe self, lower body dressing, chair/bed transfer and Substantial/maximal assistance with upper body dressing. MDS showed R1 was always incontinent of bowel and bladder. R1 had 2 Stage III and 1 Unstageable pressure ulcers that were present upon admission. MDS also showed R1 had surgical wound.

R1'S POS (Physician Order Sheet) showed the following orders but not limited to:
- Clean LT (left) elbow with NSS, skin prep peri-wound apply foam dressing one time a day every Mon, Wed, Fri AND as needed if soiled or falls off.
- Clean Coccyx with wound cleanser, skin prep peri-wound apply Hydrocolloid one time a day every Mon, Wed, Fri AND as needed if soiled or falls off.
- Skin prep staples to LT (left) AKA LOTA (leave open to air) one time a day AND as needed Apply dry dressing if drainage present.
- Readycare 1.7 two times a day for low BMI(Body Mass Index) for age 120 ml.
- Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals) Give 1 tablet by mouth one

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time a day for Wound care.
- Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth one time a day for Wound care.
- Critical Care Active Protein two times a day for Wound care give 30cc PO.

R1'S MAR (Medication Administration Record) for the month of January 2024 showed:
- Critical Care Active Protein and Readycare 1.7 were not signed that it was given on 1/15/24 and 1/20/24.

R1's TAR (Treatment Administration Record) for the month of January 2024 showed: Treatment to Coccyx and Left elbow were not signed that treatments were provided on 1/26/24.
R1's wound assessment dated 1/21/24 documented in part: Stage III to Coccyx measuring 0.5 X 0.7 X 0.3cm. No wound assessment for left elbow on 1/21/24.
No wound or skin assessment found in R1's EHR upon admission on 1/8/24 and weekly thereafter on 1/15/24. Per V4, wound assessment should be done upon admission then weekly. No wound NP notes found in R1's EHR.

R1's Braden scale assessment dated 1/8/2024 Scored 14 (moderate risk). No Braden scale assessment found on 1/15/24 and 1/22/24 found on R1's EHR. Per V4, Braden scale is done weekly x 4 weeks.

R1's care plan dated 1/10/24 documented in part: The resident has stage 3 pressure ulcer related to history of ulcers, Immobility, DM. Care plan interventions included but not limited to Administer treatments as ordered and monitor for effectiveness.

MDS dated 12/30/2023 showed R4's cognition

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was intact. R4 needed set-up/clean-up assistance with eating; Substantial/maximal assistance with oral, personal and toileting hygiene and Total assistance/dependent to staff with shower/bathe self, lower body dressing and chair/bed transfer. MDS showed R4 was always incontinent of bowel and bladder. MDS also showed R4 had Stage IV pressure ulcer that was present upon admission.

R4's POS included the following orders but not limited to:
- Sacrum: Cleanse with wound cleanser skin prep peri-wound/Alginate silver/dry dressing one time a day.
- Critical Care Active Protein three times a day Give 30ml PO.
- Multi-Vitamin/Minerals Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth in the morning for Nutritional Supplement.
- Vitamin C Oral Tablet (Ascorbic Acid) Give 1 tablet by mouth one time a day for Wound care.

R4's MAR for the month of December 2023 and January 2024 showed: Critical Care Active Protein were not signed that it was given on 12/3/23, 12/19/23. 12/22/23, 12/23/23, 12/30/23, 12/31/23 and 1/13/24. MAR showed Multi-Vitamin/Minerals Tablet and Vitamin C Oral Tablet were not signed that medications were given on 1/13/24.

R4's TAR for the month of December 2023, January and February 2024 showed: Treatment to Sacrum were not signed that treatment was provided on 12/17/23, 12/20/23, 12/23/23, 12/24/23, 1/1/24, 1/14/24, 1/23/24, 1/24/24, 1/26/24, 1/30/24, 2/3/24, 2/5/24 and 2/11/24.

R4's wound assessment dated 2/13/24

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documented pressure injury to sacrum measuring 2.0cm x 0.6cm x 0.2cm. Per wound nurse Sacrum was classified as Stage IV acquired in the facility.
R4's EHR reviewed with V4 and said it is indicated that there was no wound assessment documentation found on 12/7/23, 12/14/23, 12/21/23, 1/3/24, 1/10/24, 1/17/24 to Sacrum Stage IV pressure wound.

R4's wound NP notes dated 2/12/24 documented in part: Sacral is a Stage 4 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2cm length x 0.6cm width x 0.2 cm depth.

R4's Initial Braden scale assessment dated 2/11/22 scored 13 (moderate risk) and latest assessment dated 2/5/24 showed 14 (moderate risk).

Care plan dated 1/2/24 documented in part: R4 has pressure ulcer on sacrum r/t Immobility. R4 Care plan interventions included but not limited to:
- Administer medications as ordered.
- Administer treatments as ordered and monitor for effectiveness.
- Monitor dressing to ensure it is intact and adhering. Report lose dressing to Treatment nurse.

MDS dated 1/8/2024 showed R5 was cognitively intact. R5 needed set-up/clean up assistance with eating; Supervision/touching assistance; Total assistance/Dependent to staff with toileting hygiene, shower/bathe self, lower body dressing, chair/bed and toilet transfer and Substantial/maximal assistance with upper body

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	IL6003958	A. BUILDING: _____ B. WING _____	C 02/16/2024

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MORGAN PARK HEALTHCARE	10935 SOUTH HALSTED STREET CHICAGO, IL 60628

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dressing and personal hygiene. MDS showed he was frequently incontinent of bowel, with indwelling catheter. MDS showed 2 Stage III pressure ulcers that were not present upon admission.

Wound report provided by facility dated 2/5/24 to 2/9/24 showed R5 has the following wounds:
1. Left posterior thigh - date identified on 4/14/21, facility acquired Stage 3 pressure ulcer. Last assessment date on 2/6/24 measured 3.0 x 4.0 x 0.2cm (Length x Width x Depth).
2. Right ischium - date identified on 12/11/23, facility acquired Stage 3 pressure ulcer. Last assessment date on 2/6/24 measured 2.0 x 1.0 x 0.2cm.
3. Left ischium - date identified on 1/8/24, facility acquired Stage 3 pressure ulcer. Last assessment date on 2/6/24 measured 1.0 x 1.0 x 0.2cm.
4. Right heel - facility acquired Stage 3 pressure wound. Last assessment date on 2/6/24 measured 4.0 x 3.2 x 0.2cm. Per V4, could not determine when it started. V4 said per documentation, on May 16, 2019, it was already an existing wound.

R5's POS showed the following orders but not limited to:
- left posterior thigh cleanse with normal saline, pat dry skin prep peri wound apply moistened collagen then calcium cover with dry dressing one time a day for Wound care AND as needed Clean LT posterior thigh with NSS apply skin prep to peri-wound apply Ag+ alginate, cover with dry dressing.
- Cleanse Sacralcoxccygeal with Nss/skin prep/ pack with calcium alginate/boarder gauze one time a day.
- Ascorbic Acid Tablet 500 MG Give 1 tablet by

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mouth in the morning for Wound care.
- Multivitamin Oral Tablet (Multiple Vitamin) Give 1 tablet by mouth in the morning for Nutritional Supplement.
- Critical Care Active Protein three times a day Give 30ml PO.

No treatment orders for the following wounds: Right and left ischium and Right heel.

R5's MAR for the month of December 2023 and January 2024 showed: Critical Care Active Protein were not signed that it was given on 12/22/23, 12/23/23, 12/31/23, 1/6/24, 1/14/24 and 1/17/24. MAR showed Multi-Vitamin/Minerals Tablet and Vitamin C Oral Tablet were not signed that medications were given on 1/17/24.

R5's TAR for the month of December 2023, January and February 2024 showed: Treatment to Left posterior thigh and Sacrococcygeal wounds were not signed that treatments were provided on 12/23/23, 12/29/23, 1/14/24, 1/23/24, 1/24/24, 1/26/24, 2/3/24, 2/4/24 and 2/11/24. No treatment orders for the following wounds: Right and left ischium and Right heel.

No wound assessment documentation found for right heel wound on 12/1/23 and 12/8/23, 12/15/23 in R5's EHR. No wound assessment documentation found for Left thigh, right ischium, and right heel on 12/22/23, 12/29/23, 1/5/24. No wound assessment documentation for Left thigh, right ischium, and right heel on 1/12/24, 1/19/24 and 1/31/24.

Wound NP notes dated 2/5/24 showed R5 with multiple wounds documented in part:
- Right Ischial is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter

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measurements are 2cm length x 1cm width x 0.2 cm depth. There is no change noted in the wound progression.
- Left, Posterior Thigh is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 3cm length x 4cm width x 0.2 cm depth. There is a Moderate amount of sero-sanguineous drainage noted which has no odor. There is no change noted in the wound progression.
- Right Heel is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 4cm length x 3.2cm width x 0.1 cm depth. There is a Moderate amount of sero-sanguineous drainage noted which has no odor.

R5's Initial Braden scale assessment dated 6/22/15 scored 11 (high risk) and latest assessment dated 2/6/24 showed 13 (moderate risk).

Care plan dated 1/3/24 documented in part: R5 has a pressure ulcer to coccyx and left posterior thigh. R5 Care plan interventions included but not limited to:
- Administer supplements to promote wound healing.
- Assess and document on wounds weekly and as needed.
- Administer treatments as ordered and monitor for effectiveness.
- Change dressing as ordered.

Facility's wound policy and procedures dated 1/1/24 documented in part:
- To identify factors that places the residents at risk for the development of pressure ulcers and to implement appropriate interventions to prevent

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the development of clinically avoidable wounds.
- To promote a systemic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown.
- To promote healing of existing pressure ulcers.
- BRADEN scale should be completed for all residents upon admission/readmission for a total of four consecutive weeks, quarterly with each MDS assessment and when a significant change of condition occurs.
- Identified risk factors should be addressed in the resident's care plan to assure appropriate interventions to manage the risk are implemented.
- Upon identification of the development of a wound, the wound assessment will be documented.
- Residents should be examined thoroughly at least weekly by a licensed nurse to identify existing pressure ulcers. Findings from the weekly skin assessment should be documented/signed off by the licensed nurse.
- Any skin impairments including pressure ulcers should be assessed and documented weekly by the wound nurse or designee. Documentation should cover all pertinent characteristics of existing pressure ulcers including location, size, depth, maceration, color of the ulcer and surrounding tissues and a description of any drainage, eschar, necrosis, odor, tunneling or undermining, if warranted.
- A nutritional consultation should be completed for residents who are at risk for malnutrition.
- The goals of wound treatment are to: Protect the ulcer from contamination and promote healing.
- Measurements are taken weekly.

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