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S 000	Initial Comments Complaint Investigation: 2411581/IL170229	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 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,	S9999		

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S9999	Continued From page 1 injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999		

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S9999	Continued From page 2	S9999		

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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to identify a declining pressure wound, reassess a declining pressure wound, document changes of a declining pressure wound, and notify the decline to a care provider. This applies to 1 of 5 residents (R1) reviewed for pressure injuries in a sample of 6. These failures resulted in R1's (unstaged) pressure injury declining to a larger unstageable pressure injury, which required R1's hospitalization and extensive surgical debridement of the pressure injury.

The findings include:

R1's Facility Assessment dated 11/15/23 showed R1 was a 91-year-old female cognitively impaired resident who was at risk for developing pressure injuries. This assessment showed R1 needing maximal assistance and/or dependent on staff for

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S9999	Continued From page 3 bed turning, transfers, bathing, and personal hygiene. R1's Progress Note dated 1/2/24 at 8:39 PM showed V4 (Wound Care Nurse) documented on R1's new onset coccyx pressure injury. The measurements documented were 3 centimeters (cm) by 2.5 cm by 0.5 cm, serosanguinous drainage, and a brown/yellow wound bed. This progress note showed no staging classification for the wound, or if the wound had any signs of infection present. On 2/28/24 at 12:30 PM, V4 stated she could not remember who or how she was notified of R1's pressure wound. V4 stated she put the progress note in, contacted the Nurse Practitioner (NP), received new orders, and placed the dressing on R1. V4 stated she was never notified of R1's wound declining after she had seen it on 1/2/24. V4 stated she planned to see R1's wound on 1/9/24 to take new measurements, but R1 was already discharged out of the facility. V4 stated if there are changes to a pressure wound (bigger, odor, infection, etc.) the nursing staff should notify myself or a provider for new orders. On 2/27/24 at 3:50 PM V17 (Licensed Practical Nurse/LPN) stated if a wound is new it needs to be assessed and documented. The physician/NP should be notified for orders. V17 stated if a dressing change was new the nurse should check the last wound notes to see if there were any problems with the wound. If it is worse or has signs of infection (odor or discharge) the physician/NP and wound nurse need to be notified to update the treatment orders. The orders may include cultures or labs to verify infection. The changes should be documented in a wound assessment, wound progress note,	S9999		

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S9999	Continued From page 4	S9999		

and/or a progress note of who was being notified.

On 2/28/24 at 10:30 AM, V12 (Certified Nursing Assistant/CNA) stated she remembered R1 had a wound on her butt near the top. The rest of her bottom was red and looked "rough". The dressing was wet and fallen off. The wound was white and with a little blood on it. The nurse had to put a new dressing on. V12 stated she did not remember who the nurse was on that day.

On 2/29/24 at 1:00 PM, V10 (CNA) stated when rounding on R1 there was a smell of something coming from R1's room. V10 stated she checked to see if R1 needed to be changed several times due to the odor. V10 stated the smell was "one of those fleshy infected smells." V10 stated she let the nurse know at that time. V10 could not remember who the nurse was she reported to.

The facility's working schedule dated 1/2/24-1/9/24 showed V12 worked 1/3/24 and 1/4/24 on R1's unit. This showed V10 worked 1/8/24 on R1's unit.

R1's Treatment Administration Record (TAR) printed on 2/27/24 showed V28 (Agency Nurse) provided R1's dressing change on 1/4/24 and 1/8/24. R1's medical record has no progress notes, wound notes, or documentation completed by V28 referring to R1's wound condition for these dressing changes.

On 2/28/24 at 10:14 AM V28 (Agency Nurse) stated she performed a lot of dressing changes when she worked at the facility. V28 stated if the TAR is checked off it means the dressing change was completed by her. V28 stated she did not remember any specific residents dressing changes. V28 stated if a wound is "bad" it needs

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S9999	Continued From page 5	S9999		

to be documented at the time of the dressing change. Look at the previous wound notes, and if it's different or infected the wound nurse needs to be notified.

On 2/27/24 at 3:40 PM V13 (CNA) stated R1 did have a wound at the top of her bottom before she left. V13 stated at first it was about the size of a quarter. V13 stated later in the week it was bigger, and it had a dark ring around it like it was bruised.

The facility's working schedule dated 1/2/24-1/9/24 showed V13 worked 1/4/24, 1/6/24, and 1/7/24 on R1's unit.

R1's TAR printed on 2/27/24 showed V29 (LPN) provided R1's dressing changes for 1/6/24 and 1/7/24. R1 medical record has no progress notes, wound notes, or documentation completed by V29 referring to R1's wound condition for this dressing change.

During the survey, multiple attempts were made to contact V29 by phone. Messages were left to call the facility or surveyor's office. V29 did not call back at any time during the survey.

On 2/29/24 at 1:27 PM, V11 (CNA) stated she worked the night shift the day before R1 was sent to the hospital (1/7/24). V11 stated she was cleaning up R1, and R1's dressing had come off. V11 stated the wound was located at the top R1's buttocks. The wound was about 2 inches across, and the center of the wound was black in color. V11 stated she let V14 (LPN) know the dressing needed to be changed. V11 stated she had turned R1 so V14 could place a dressing on R1's wound. V14 was the only male nurse working that unit at the time.

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S9999	Continued From page 6	S9999		

The facility's working schedule showed on 1/7/24 V14 (LPN) was the night nurse working R1's unit.

On 2/28/24 at 1:22 PM, V14 stated he did not remember a replacing a dressing on R1 during the night shifts. V14 stated if there is a new or worsening wound you check the previous notes and orders. If there is a problem the wound care nurse, following physician/NP, and/or the director of nursing should be notified. The oncoming day shift nurse should be told about the wound to make sure it would be followed up on during the day shift.

R1's medical record showed no documentation (assessments, progress notes, wound notes) by V14 referencing R1's wound condition or reapplying a dressing during the 1/7/24 night shift.

On 2/29/24 at 1:15 PM, V20 (Wound Nurse Practitioner/NP) stated when we get to the facility, we are provided a list of residents with wounds we need to round on. Residents with new wounds should be added to the list. V20 stated I was in the facility on 1/4/24 but was not notified R1 needed to be seen. V20 stated R1 is a resident they had seen in the past, but she had not seen her since August of 2023. V20 stated she was informed about seeing R1 the next week, but R1 was already admitted to the hospital before I could see her. V20 stated she was not contacted for any wound orders for R1. V20 stated if there are changes to the size of a wound, odor, darkening of color, signs, and symptoms of infection, or increase in discharge somebody should be notified so something can be done for the wound care.

V48's (R1's NP) Provider Progress Note dated

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S9999	Continued From page 7 1/5/24 showed V48 was notified of R1's new leg wound, and wound care would be managing the wound care orders. This progress note makes no references to R1 having a new coccyx wound. V48 was unavailable for interview during the survey. On 2/27/24 at 7:55 PM, V15 (LPN) stated in the early morning (1/9/24) she was notified by a CNA that R1 was not doing well. V15 stated when she assessed R1 she was clammy, slightly short of breath and had swelling on the right side of her neck. V15 stated R1 had a history of parotid gland (neck saliva gland) infections. V15 sent R1 out to a local hospital where she was previously treated. V15 stated it was reported to her R1 had a coccyx wound, but she did not have to change or replace R1's dressing. On 2/28/24 at 11:50 AM, V9 (Advanced Practice Registered Nurse/APRN at the Emergency Department/ED) stated she was the provider who took care of R1 when R1 arrived to the ED. R1 was symptomatic for sepsis in the ED. When we went to turn R1 on their sides a foul odor started coming from R1. R1 had a 2-3-inch round pressure wound on her coccyx. V9 stated when she placed her finger in the edge of the wound, she could touch bone. The wound had purulent dark drainage, and the bottom of the wound was black. R1 had lab values correlating with being septic. R1's white cell count was just over 25.1 (high) and a lactic acid of 4.8 (very high). V9 stated she admitted R1 to the hospital's Intensive Care Unit (ICU) due to the level of infection. R1 was consulted with a general surgeon for a wound debridement. R1's hospital records dated 2/29/24 showed R1 was seen in the Emergency Department (ED) on	S9999		

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S9999	Continued From page 8 1/9/24 at 4:36 AM. These records showed R1's ED skin notes having a "large unstageable coccyx decubitus pressure ulcer present, with copious purulent drainage and tunneling present." In the ED R1 was started on Cefepime (Maxipime) 2 Grams IV and Clindamycin 900 mg IV antibiotics for sepsis. R1's hospital records showed R1 was admitted to the hospital with the diagnoses: 1. Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present 2. Atrial flutter with rapid ventricular response. 3. Pressure injury of contiguous region involving back and buttock, unstageable, unspecified laterality. R1's hospital records dated 2/29/24 showed R1 had a wound debridement procedure on 1/9/24. The surgical procedure summary showed: The tissue was dead down to the bone. The wound was 30cm x 10cm x 4cm deep. Approximately 25% of this wound was down to the bone. The other 75% was taken down to the muscle fascia. R1's Death certificate dated 1/19/24 showed R1 expired on 1/19/24 with causes of death listed as: Multiple organ failure, sepsis, and coccyx decubitus pressure ulcer. The facility's Pressure Injury Policy dated 3/2/21 showed Pressure and other injuries will be assessed weekly or as needed by facility staff or consulting clinician by utilizing a WASA (assessment tool) or other consulting clinician's evaluation. A comprehensive pressure injury evaluation will be completed for identified pressure injuries. Also, at lease daily, staff should remain alert for potential changes in the skin condition during resident care. R1's medical record had no entries of any	S9999		

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S9999	Continued From page 9 WASAs, or Comprehensive Pressure Injury Evaluations done at the time or after R1's coccyx wound was found on 1/2/24. R1's medical record showed no documentation of R1's care plan being reviewed or having updated interventions placed after R1's coccyx wound was found on 1/2/24. "A"	S9999		