STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

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S 000	Initial Comments Complaint Investigation 2390101/IL155004	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)5) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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. 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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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to identify pressure injuries prior to wounds becoming unstageable and failed to ensure residents with unstageable wounds received wound assessments, monitoring, and treatments for 2 of 3 residents (R6, R14) reviewed for pressure injuries in the sample of 14. These failures resulted in R6 developing 6 new pressure injuries, and two existing unstageable pressure injuries with worsening and decline of the wounds. These failures also resulted in R14 developing one new pressure injury. The findings include: 1. On 1/6/23 at 9:35 AM, R6 was in bed flat on his back with his heels resting on the mattress. R6 was alert and oriented and said he was admitted to the facility in October due to a car accident. R6 said he is unable to walk and is bedridden due the car accident and history of back surgeries. R6 said due to pain he is unable to turn himself in bed and requires assistance from staff to turn. R6 said he has bed sores on his bottom that he didn't come into the facility with. R6 said he has nerve like pain in his feet, and pain in his back/bottom area. R6 said he had a dressing on his bottom, but he was not sure how long ago it was changed. R6 said the wound doctor comes in but has not for a month or so. R6 said he has gone a	S9999		

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S9999	Continued From page 3 week or so without a dressing change and thinks the last dressing change was around mid-December. R6 said he can't recall anyone measuring his wounds. R6's Initial Skin Alteration Review dated 10/18/22 shows R6 was admitted on 10/15/22 and has one partial thickness wound classified as a skin tear/abrasion on his right trochanter. R6's Wound and Skin Alteration Review dated 12/8/22 shows R6 has a "new wound, right lower back, unstageable pressure injury measuring 3 x 3.5 x 0 cm, with 100% black eschar wound bed with no drainage." R6's Wound and Skin Alteration Review dated 12/8/22 shows R6 has a "new wound, sacrum, unstageable pressure injury measuring 8 x 6 x 0 cm, 50 % black eschar wound bed with regular edges and scant drainage with no odor." R6's Wound Physician Notes dated 12/8/22 shows R6 has "unstageable pressure wound to right lower back, measures 3 x 3.5 x 0 cm. Wound is 100% necrotic tissue with mild serous exudate; unstageable pressure wound to sacrum, measures 8 x 6 x 0 cm. Wound is 50% necrotic with mild serous exudate...recommend silvadene and dry dressing daily and as needed...Due to patient's multiple comorbidities he is at high risk for developing new and worsening wounds." R6's Wound and Skin Alteration Review dated 12/15/22 (one week later) shows R6's right lower back unstageable pressure wound measures 3 x 3.1 x 0 cm, with 100% black eschar wound bed and scant serosanguinous (clear bloody) drainage.	S9999		

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S9999	Continued From page 4 R6's Wound and Skin Alteration Review dated 12/15/22 (one week later) shows R6's sacral unstageable pressure wound measures 8 x 6 x 0 cm, with 60% black eschar wound bed with irregular edges and moderate (25%-75%) serosanguinous (clear bloody) and sanguineous (bloody) drainage. R6's Wound Physician Notes dated 12/15/22 shows R6 has "unstageable pressure wound to right lower back, measures 3 x 3.1 x 0 cm. Wound is 100% necrotic tissue with mild serous exudate; unstageable pressure wound to sacrum, measures 8 x 6 x 0 cm. Wound is 60% necrotic with mild serous exudate...recommend silvadene and dry dressing daily and as needed...Due to patient's multiple comorbidities he is at high risk for developing new and worsening wounds." R6's wound assessments showed there were no assessments performed after 12/15/22 (22 days ago). On 1/6/23 at 10:34 AM, V8 (Licensed Practical Nurse/LPN) said she was the nurse assigned for R6 and was not sure of who had wounds on the floor, who does dressings changes, or if the facility had a wound nurse. On 1/6/23 at 10:51 AM, V14 (Registered Nurse/RN) said there is no wound nurse currently, the wound nurse left about a month ago. V14 said the floor nurses should be doing the dressing changes and wound assessments. V14 said she hasn't seen the wound doctor since the wound nurse left. On 1/6/23 at 11:10 AM, V3 (Assistant Administrator) said there is no wound nurse since the last one left. V3 said V16 (Corporate RN) was	S9999		

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S9999	Continued From page 5	S9999		

handling treatments but she is not in the facility now. V3 said there were no other skin assessments for R6 after 12/15/22 (22 days ago). V3 said she was not sure when the wound doctor came to the facility and there were no other wound doctor notes.

On 1/6/23 at 12:02 PM, V7 and V10 (Certified Nursing Assistants/CNA) lowered R6's brief and assisted R6 to roll to his left side in the bed. R6 had a gauze type dressing saturated with purulent drainage on his bottom which began to drain in a stream down R6's back, a blood saturated gauze type dressing to R6's right lower back, and a gauze type dressing on R6's lower left leg that was saturated with blood which had saturated the sheet on the bed and formed a pool of blood on the mattress. R6's right and left heel contained large dark purple areas, and R6 had a round red open area over a vertebra on the middle of his back. V2 (Director of Nursing/DON) stated "These dressings have not been changed in a while; that looks like pus running out of the sacral wound. I only saw treatments for 3 wounds for R6. I'm not aware of any new wounds." V2 removed the dressings on R6's lower back and sacral area. The sacral area had 4 separate wounds, two larger areas and two smaller round areas. The wound on the top right of the sacral area was filled with yellow/brown colored slough and continued to drain purulent pus like fluid. The wound on the top left area and the two smaller round areas on the bottom left and bottom right side had exposed white areas (resembling tendon) in the wound beds. The wound on R6's right lower back was red, deep, and appeared to have undermining and tunneling. V2 stated "Yes I see that white area. I'm not sure if that's tendon or bone." V2 said she had not measured wounds in a while and began to measure R6's wounds:

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S9999	Continued From page 6 right lower back 2 cm x 2.5 cm, deep, red, with undermining and possible tunneling right upper sacral wound 3.5 x 2.5 cm, filled with slough and draining purulent pus left upper sacral wound 5 x 2.5 cm, white tendon like area left lower sacral wound .5 x .75 cm, white tendon like area right lower sacral wound .5 x .5 cm, white tendon like area low middle back wound .8 x 5 cm, open pink area left heel 2.5 x 1.5 cm, dark purple, irregular edges right heel 4 x 6 cm, dark purple, irregular edges V2 did not measure depth of any of the wounds. V2 cleansed the wounds and applied a dressing to all the wounds. V2 stated "I had no idea about these wounds. We don't have a wound nurse and we need one. I will have to call the doctor and get an antibiotic. The one wound looks infected." On 1/6/23 at 1:21 PM, V15 (Nurse Practitioner/NP) said she was aware that R6 had some wounds and was referred to the wound doctor. V15 said she had never spoke to the wound doctor and was not aware of any new wounds for R6. V15 stated "I would expect them (facility staff) to contact the wound doctor for any new wounds. I don't get involved with wounds." R6's Treatment Administration Record (TAR) for December of 2022 shows treatment orders to cleanse with normal saline and apply silvadene and cover with dry dressing daily and as needed for R6's sacrum and right lower back. The last treatment for R6's sacral and right lower back wounds was signed off as completed on 12/23/22, and no treatments have been signed off for January of 2023 (14 days no dressing	S9999		

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S9999	Continued From page 7 changes). On 1/6/23 at 1:24 PM, V16 (Corporate Nurse) said she had been assisting with wounds since the wound nurse left, but she has been gone for two weeks. V16 said she left on 12/22/22. V16 said she was assessing wounds weekly (Thursdays) including measuring and changing treatment orders as needed. V16 said she would round with the wound NP weekly. V16 said wounds should be assessed weekly in order to determine if the wound is healing or declining, and the assessments include measuring the wounds. V16 said residents' skin and wounds should be assessed daily and at any interaction with the resident during care. V16 said any skin alterations should be reported to the nurse. V16 said treatments should be provided as ordered to keep the wound clean, prevent infection, and to promote a healing environment. V16 said she was aware of R6's unstageable pressure to the sacrum and the right back. V16 said skin assessments are done by staff during bed baths or showers, and there is an assigned skin assessment task for the RN to do. V16 said if the wound nurse is not in the facility the floor nurses are supposed to do the treatments as ordered and weekly skin assessments. V16 said she told V18 (Wound NP) that she was going to be out of the facility but was not sure why V18 was not coming to the facility while she (V16) was gone. On 1/6/23 at 2:23 PM, V6 (Assistant Administrator) said she was not aware that no one was monitoring and assessing wounds since V16 has been gone, and she (V6) was not aware that the wound doctor was not coming to the facility. R6's Care Plan dated 10/17/22 shows R6 is at	S9999		

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S9999	Continued From page 8 increased risk for alteration in skin integrity related to diagnosis of fracture of the left acetabulum, vertebrogenic low back pain, pain in left hip...R6 has shearing to the right hip, old surgical scar to the lower back...feet and heels are intact. Interventions: any new skin integrity issues/concerns will be conveyed to charge nurse, weekly measurements and documentation, administer wound care (treatments) per physician orders. The same care plan shows initiated on 12/8/22 resident with unstageable wound to right lower back and sacrum with interventions: consult wound physician, weekly wound measurements, skin will be checked during routine care, provide treatment as per physician order. The facility's undated Pressure Ulcer Prevention Policy shows "Purpose: to prevent and treat pressure sores...inspect the skin several times daily during bathing, hygiene, and repositioning measures. New or worsened skin concerns should be reported immediately to the nurse for follow up treatment...NOTE: Daily skin checks will be done by CNAs during routine care." 2. On 1/6/23 at 11:15 AM, R14 was in bed with the left side of the bed against the wall. R14's left leg was slightly bent at the knee touching the wall. There were no pillows or padding between the wall and R14's knee. R14 stated "I have a pressure sore of my left knee. I got it from my left knee being scrunched and against the wall. I'm paralyzed and don't realize it. They just changed the dressing now. It's supposed to be every night. Lately it's been more like every other night. The wound doctor came once, and the wound NP would come weekly but I haven't seen her in a while. I'm not sure if they measure it; I've just seen them look at it."	S9999		

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S9999	Continued From page 9 R14's Treatment Nurse Initial Skin Alteration Review dated 11/18/22 shows R14 has a new facility acquired unstageable pressure injury to her left knee. The wound measures 1.5 x 1.8 x 0 cm and is 100% necrotic. On 1/6/23 at 1:32 PM, V16 (Corporate RN) said R14 was found to have a pressure to her left knee caused by her knee being against the wall. V16 said "Treatment orders are in place, and we moved her bed slightly away from the wall so there is space between her knee and the wall." V16 said R14 should have weekly skin assessments for the wound. R14's most recent Wound and Skin Alteration Review of the left knee pressure injury is dated 12/15/22 (22 days ago). On 1/6/23 at 2:23 PM, V6 (Assistant Administrator) said there were no more skin assessments for R14's left knee; the 12/15/22 was the most recent assessment. R14's Care Plan dated 10/18/22 shows "skin will be checked during routine care." (A)	S9999		