Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006506	A. BUILDING: ______ B. WING ______	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION NAZARETHVILLE PLACE	300 NORTH RIVER ROAD DES PLAINES, IL 60016

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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:

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.

These Regulations were not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to implement interventions in preventing the development of a pressure ulcer in relation to repositioning and skin monitoring for one (R12) resident reviewed for pressure ulcers. This deficiency resulted in R12's stage III pressure ulcer in the coccyx area worsen to stage IV pressure ulcer with ongoing infection requiring antibiotic therapy.

Findings include:

R12 is a 88-year-old female admitted to the facility on 02/08/2022 with diagnoses including but not limited to Hypertensive Heart Disease with Heart Failure; Paroxysmal Atrial Fibrillation;

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S9999	Continued From page 2 Unspecified Osteoarthritis, Unspecified Site; Dysphasia, Oropharyngeal Phase; and Unsteadiness on Feet. According to MDS (Minimum Data Set) dated 10/25/2022 under Section C, R12 has a BIMS (Brief Interview of Mental Status) score of 12 indicating a moderately impairment of cognitive functioning. According to MDS (Minimum Data Set) dated 10/25/2022 under Section G, R12 requires extensive assist of two + person physical assist in Bed Mobily including turning side to side. According to MDS (Minimum Data Set) dated 10/25/2022 under Section M, R12 is at risk for developing pressure ulcers/injuries and has one stage four pressure ulcer that was not present upon admission. On 11/14/22 at 11:04 AM Surveyor observed R12 lying in bed in supine position. R12 utilizing low air loss mattress, set up to static mode. Upon interview R12 stated, "I have a wound on my behind". Per record review, progress note completed by V14 (Registered Nurse) dated 10/15/2022 reads in part, "Stage III wound in coccyx area. 2cm x 3cm x 05cm. Cleaned and secured. Will endorse to next shift". No previous documentation pertaining R12's wound present. On 11/15/22 at 9:47 AM Surveyor observed R12's wound dressing change. V8 (Registered Nurse, corporate/mobile MDS) and V9 ((Licensed Practical Nurse) performed dressing change. V8 (RN) stated, "Wound clinic has been following R2's wound. R12 has a stage IV pressure ulcer on coccyx. It is also infected, which R12 gets antibiotics for. I'm just helping lately with wound	S9999		

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care, since the Assistant Director of Nursing has been gone; it used to be the ADON who took care of wounds at the facility. ADON been gone since the beginning of October of this year". V9 (LPN) stated, "ADON was a wound care nurse from Monday to Friday and staff nurses would do wound care on the weekends. ADON did rounds with wound doctor as well". Wound dressing change observed, wound measurements 4cmx5cmx2.5cm appearing as "tennis ball" size with additional underlining and tunneling. Wound dressing changed per order.

Plan of Service dated 10/21/2022 reads in part, "Santyl ointment coccyx wound cleanse with normal saline, apply nickel layer of Santyl, pack with Calcium Alginate and cover with boarded foam dressing daily and PRN.

On 11/15/2022 at 10:02 AM Surveyor interviewed V9 (LPN), V9 stated, "Nursing staff usually checks the residents' body, including skin assessment, daily. R12 developed some skin redness at some point, and preventative dressing was utilized at that time". Surveyor clarified how could R12 develop such significant wound, V9 (LPN) stated, "Lack of supplements or repositioning could cause a pressure ulcer to develop. R12 is also on antibiotic therapy for suspected osteomyelitis. There is no wound doctor in the facility, R12 has appointments every Friday with the wound doctor, and she has seen infection disease doctor as well".

Plan of Service dated 11/10/2022 reads in part, "Cefdinir 300mg capsule, take 1 capsule by mouth every 12 hours for 14 days".

Per record review, progress note completed by V11 (wound doctor) dated 10/21/2022 reads in

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part, "Pressure ulcer to coccyx, measurements 5cm x 4cm x 2.5cm with undermining. You need to relieve the pressure as best as possible; this is achieved by repositioning every 2 hours".

Per record review, progress note completed by V11 (wound doctor) dated 10/28/2022 reads in part, "The wound measures 4.8cm x 4cm x 2.6cm. There is no tunneling or undermining noted. Wound cultures reviewed and noted to have proteus mirabilis sensitive cephalosporins, refer to infectious disease for possible osteomyelitis noted on the x-ray sacrum. Cefdinir prescribed for patient".

Per record review, progress note completed by V11 (wound doctor) dated 11/04/2022 reads in part, "The wound measures 4cm x 4cm x 2.4cm".

Per record review, progress note completed by V11 (wound doctor) dated 11/11/2022 reads in part, "The wound measures 3.8cm x 3.8cm x 2.4cm. There is undermining starting at 7:00 and ending at 9:00 with a maximum distance of 2cm".

Per record review, progress note completed by V13 (infectious disease doctor) dated 11/10/2022 reads in part, "[R12] referred for evaluation due to concern for osteomyelitis in the sacrum. Sacrococcygeal wound pressure ulcer stage IV [with] possible osteomyelitis underlying the wound bed with bony changes on x-ray. Continue with oral Cefdinir without stopping for the next 2 to 3 weeks".

On 11/15/22 at 10:18 AM Surveyor interviewed V10 (Certified Nursing Assistant), V10 stated, "If I see any resident skin changes, I notify a nurse, even if it's a little redness. I check residents' skin daily, when I perform incontinence care, which is

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about every 2 hours. I noticed that R12 had a blister forming in late September 2022, so I notified nurse on duty. Assistant Director Of Nursing was also aware of R12's skin assessment change". V10 (CNA) further indicated that there were multiple management changes in early October 2022 and R12's wound must have gotten overlooked.

On 11/15/22 at 11:48 AM Resident noted in supine position, air mattress activated in static mode.

On 11/15/22 at 1:52 PM Resident remaining in supine position.

Plan of Service dated 10/16/2022 reads in part, "Reposition every 2 hours".

Plan of Service dated 10/30/2022 reads in part, "Turn and reposition every 2 hours and document the turning schedule".

On 11/16/2022 at 1:43 PM Surveyor interviewed V12 (acting Director of Nursing), V12 stated, "Wound can develop due to several reasons, it's based on individual case though, wounds can develop due to residents' weakness, thin skin, poor nutrient intake, supplements and medications. We look at the patient as a whole and see if they are at risk. To prevent wound development staff should make sure individually based preventative devices are in place, barrier cream is being utilized, incontinence care is provided, including every 2 hours checks for wetness, and repositioning, especially bed ridden residents".

On 11/16/2022 at 2:00 PM V1 (administrator) presented Root Cause Analysis pertaining to

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S9999	Continued From page 6 R12's wound development, no date provided, document reads in part, "What human factors were relevant to the outcome? Previous Director of Nursing and Assistant Director of Nursing did all skin assessments, evaluations, and treatments. Documentation not always completed. Was the staff properly qualified and currently competent for their responsibilities at the time of the event? [Facility] floor nursing staff were qualified to do skin evaluation and documentation but were told by previous Director of Nursing that they were not allowed to do it". On 11/16/22 at 2:50 PM Surveyor interviewed V11 (Wound Doctor), V11 stated, "Stage IV pressure ulcer could develop due to lack of reposition or poor nutrition. There are other factors such as aging frail skin. Incontinence care plays a big role, especially in the sacral area where a wound gets contaminated easily. Frequent repositioning and incontinence care would help with wound deterioration". Care plan for Risk for Impaired Skin Integrity related to Decreased Mobility, Bowel and Bladder Incontinence, dated 02/21/2022 reads in part, "Daily skin inspections, report any changes in skin or signs of possible skin breakdown; Assist R12 with turning and repositioning at regular intervals and as needed". Care plan for Impaired Skin Integrity as evidenced by Pressure Ulcer to Coccyx dated 10/15/2022 reads in part, "Daily skin check and record; Assist with turning and repositioning at regular intervals and as needed". Pressure Injury Assessment/Treatment policy dated 12/2016 reads in part, "The pressure injury treatment program should focus on the following	S9999		

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S9999	Continued From page 7 strategies: Resolution of current pressure injuries and prevention of additional pressure injuries; Managing and preventing bacterial colonization and infection. Interventions/Care Strategies: Eliminate or reduce the source of pressure using positioning techniques; Preventative measures to reduce the risk of further tissue loss; Managing and reducing the risk of infections; Interventions that increase the potential for healing". (B)	S9999		