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	IL6004055	A. BUILDING: _____ B. WING _____	C 01/31/2024

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SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

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S 000	Initial Comments Complaint Investigation 2450711/IL169151	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d3)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. 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, injury or change in condition at the time	S9999		

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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

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pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on interview, observation and record review, the facility failed to provide accurate skin assessments and/or ensure preventative treatment and services were implemented to prevent the development of pressure ulcers for 1 of 5 residents (R1) reviewed for pressure ulcers in a sample of 7. This failure resulted in R1 developing unstageable DTI's (deep tissue injuries) to the right and left heel with undetermined thickness.

The findings include:

R1's face sheet documents R1 was admitted to the facility on 12/4/23. R1's Physician's orders dated 12/4/23-12/31/23 list some of R1's diagnoses as UTI (urinary tract infection), A-Fib (Atrial fibrillation), HTN (hypertension), seizure disorder, dementia, AKI (Acute kidney injury), and HLD (hyperlipidemia).

R1's MDS (Minimum Data Set) dated 12/8/23 documents a BIMS (Brief Interview for Mental Status) score of 03, indicating R1 has severe cognitive impairment. This same MDS, in Section GG, documents R1 is dependent for rolling left and right in bed, sit to lying, lying to sitting on the side of bed, chair/bed to chair transfers. Section M documents R1 is at risk of developing pressure ulcers/injuries and has one or more unhealed pressure ulcers/injuries. Section M also

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documents R1 was given a pressure reducing device for the bed and put on a turning and repositioning program. R1's section M contained no other documentation regarding pressure ulcers.

R1's care plan dated 12/18/23 document a focus category of dependent for transfer/mobility-Unable to assist/Assists only minimally and includes documented interventions of "Bed Mobility-The resident is totally dependent on staff for repositioning and turning in bed" and "T&P (turn and position) q (every) 2 hours while awake." The focus category documents "per Braden Risk Score-High, resident has risk factors may lead to pressure ulcer formation." The following interventions are documented: CNA (Certified Nurse Assistant) to assess skin during cares and head to toe during shower/bed bath, report any reddened or open areas to nurse, daily skin check for impairment/issues, report any new areas of impairment to practitioner for follow up, encourage/assist to prop pressure areas to avoid contact skin to skin or prolonged contact with surfaces, as resident allows, float heels while in bed, as resident allows while awake, turn and reposition, as resident allows while sleeping, turn and reposition, pressure reducing cushion while in bed, and pressure reducing cushion while up in chair.

R1's Nursing Admission Assessment dated 12/4/23 documents the following for pressure areas: small area on back et (and) along spine, small area on sacrum, areas to bilateral heels signed by V8 (LPN/Licensed Practical Nurse). R2's "Braden Scale for Predicting Pressure Ulcer Risk" dated 12/4/23 documents a score of 8, which indicates R1 is at high risk for developing pressure ulcers and is signed by V8. The same

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assessment under "wound review" documents "Y" (yes) to the question of "Does the resident currently have an unresolved pressure ulcers? (If yes, please see weekly wound measurement)" Under "Skin Treatment Review: Indicate all used in the last 7 days" float heels is marked as being used. V8's nurse progress note dated 12/4/23 at 10:00pm, documents a Body Assessment was completed, and R1 has reddened pressure areas on back, spine, sacrum, et (and) bilateral heels. Right heel has a 0.5 x 1 cm (centimeter) scabs intact. R1's nursing summary dated 1/16/24 and signed by V8 notes for skin care, pressure relief mattress and heel protectors and notes heels are soft.

R1's Braden Scale for Predicting Pressure Ulcer Risk documented by V9 (LPN/Licensed Practical Nurse) dated 12/11/23, 12/18/23, 12/25/23 and 1/1/24, all document a score of 15, which indicates R1 is at high risk of developing pressure ulcers. The wound review section for all of the above dates has a line drawn through the column which asks, "Does the resident currently have any unresolved pressure ulcers?"

R1's "Physician's Orders" dated 12/4/23 to 12/31/23 documents R1 is a moderate skin risk and documents an order of "weekly skin assessment with note on Monday shift 2-10." R1's Physician's orders dated 1/1/24-1/31/24 document an order dated 12/4/23 for weekly skin assessment with note on Monday 2-10 shift and a new order dated 1/29/24 for daily skin checks on 6-2 shift.

R1's Skilled Progress notes from 12/4/23 to 1/22/24 indicate there was no documentation of wound location, measurements, drainage or treatment. A Skilled Progress note dated 1/23/24

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at 1:30pm by V9 documents N.O. (new order) received from wound physician to apply betadine to bilateral heels bid (twice a day), son notified. A Skilled Progress Note dated 1/30/24 at 9:00am by V7 (RN/Registered Nurse) documents pressure areas to bilateral heels remain but appear to be improving. Tx (treatment) to bilateral heels performed. There was no documentation noted from 1/23/24 to 1/30/24 of wound location, measurements, drainage or treatment.

R1's TARS (Treatment Administration Record) dated 12/4/23-12/31/23 document weekly skin assessments on Monday 2-10 shift. Initials indicating assessment were completed were documented on the following dates: 12/4/23, 12/11/23, 12/18/23, 12/19/23, and 12/25/23. The back of the TAR documents a skin assessment on 12/19/23 and notes "skin assessment performed post shower" and "no new areas observed" and signed by V7. There were no other skin assessments documented on the back of the TAR or in the nurse progress notes. There was no documentation noted under location, stage, diameter, depth/shape/type, color or drainage. R1's TARS dated 1/1/24-1/31/24 were reviewed and document skin assessments were initialed as being completed on the following dates: 1/1/24, 1/8/24, 1/15/24, 1/22/24, and 1/23/24. The skin assessment on the back of the TAR on 1/1/24, 1/8/24, 1/15/24, and 1/22/24 all document "no new skin issues" under progress/comments. On 1/23/24 under progress/ comments it documents "Skin assessment performed post shower. Pressure areas remain to bilateral heels. No new areas observed." There was no documentation noted under location, stage, diameter, depth/shape/type, color or drainage.

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R1's "Initial Wound Evaluation and Management Summary" dated 1/25/24 by V12 (Wound Physician) documents R1 has an unstageable DTI of the right heel, undetermined thickness. Etiology is noted as pressure with a duration of > (greater than) 6 days. The wound measurement to the right heel is noted as 2.5 x 3 x not measurable cm (centimeters), exudate: none and skin: intact with purple/maroon discoloration. The same evaluation also documents an unstageable DTI of the left heel, undetermined thickness, with a documented etiology of pressure with a duration of > 6 days. The wound measurement of the left hell is noted as 0.9 x 0.9 x not measurable cm, exudate: none, skin: intact with purple/maroon discoloration.

On 1/26/23 at 8:30am, R1's skin check, completed by V9 (LPN), was observed. There were no wounds observed to R1's back or spine. R1's coccyx is lightly reddened. R1's left heel has an approximately 1-centimeter (cm) x 1 cm black area, then a 4 cm x 3 cm boggy area around bottom of heel and is darker pink in color. R1's right heel has 4 cm x 3 cm black area with a small area of yellow tissue in the middle. There was no drainage noted from either wound. The surrounding tissue on both wounds is light red.

On 1/26/24 at 8:40am, R1 was observed lying in bed without heel protectors on. V10 (CNA/Certified Nurse Assistant) then applied heel protectors.

On 1/26/24 at 9:00am, V1 (Administrator) said she did not have any wound notes or wound assessments on R1 prior to 1/25/24.

On 1/26/24 at 12:51pm, V8 (LPN) said she admitted R1 to the facility. V8 said R1 did not

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have an open area on her left heel but did have a scabbed area on her right heel. V8 said R1's heels were "boggy". V8 said R1 had heel protectors on at first, then she wasn't wearing them. V8 said she did not contact the physician regarding the open areas on R1's body when she admitted her. V8 said she did not look at R1's heels and did not measure them after she admitted her. V8 said she did sign off as doing a skin assessment but did not do an assessment or look at her heels. V8 said she would consider heels to be a part of a skin assessment.

On 1/26/24 at 12:31pm, V7 (RN/Registered Nurse) said she was shown R1's wounds by Physical Therapy. V7 said R1 usually gets her showers on the evening shift, and she usually does not do the skin checks on her since they are done on 2-10 shift. V7 said she did report the wounds to V9 (Licensed Practical Nurse/ LPN) and he was supposed to get ahold of the V12 (Wound Physician). V7 said she knew R1 was admitted to the facility with a wound as she did read her admission assessment. V7 said she did not call the physician since she assumed V9 called him.

On 1/26/24 at 9:05am, V9 (Licensed Practical Nurse/LPN) said he guesses they just dropped the ball on R1's wound care. V9 said he asked staff if they saw an ulcer on R1's feet because some were charting it and some were not. V9 said he became aware of the ulcers on her heels on 1/23/24 and he called physician and V12 (Wound Physician). V9 said the wound physician came to see R1 on 1/25/24.

On 1/26/24 at 9:30am, V9 said they just missed the wounds and he just found out about them. V9 said the wounds were not charted on due to staff

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thinking he knew about them, and he didn't or he would have notified the physician and got orders for wound care.

On 1/26/24 at 10:14am, V5 (LPN) said she was aware of the open areas on R1's heels. V5 said she did keep R1's heels floated. V5 said she was aware on 1/18/24 as her and V9 spoke about it, and she did not call the physician. V5 said she figured someone else had called him. V5 said she just did a check mark on R1's skin assessment and did not do a note or an assessment. V5 said she did pass it on about her heels and guesses she didn't know where it went from there. V5 said she thinks it was on 1/18/24. V5 said she would expect a resident's heels to be a part of a skin assessment.

On 1/26/24 at 11:30am, V6 (Regional Quality Assurance) said she would expect heels to be a part of a skin assessment and it to be documented on the back of the TAR (Treatment Administration Record) or in the nurses note.

The facility policy titled "Pressure Sore Prevention Guidelines" (Revised 4/06) document "The nurse will complete a skin assessment on all residents upon admission then weekly for four weeks...The following guidelines will be implemented for any resident assessed at a Moderate Risk or High Risk, Some Interventions listed for high risk include turn and reposition every 2 hours, special mattress, positioning devices prn (as needed), daily skin checks." The same document notes turn and reposition every 2 hours, weekly skin checks, care plan entry. The same document states "Any resident scoring a high or moderate risk for skin breakdown will be noted on the treatment sheet and signed off by the nurse. In addition, a brief weekly narrative will be

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S9999	Continued From page 9 completed describing the resident's skin condition on the back of the treatment sheet." A facility policy titled "Decubitus Care/Pressure Areas" (revised 5/07) documents "it is the facility policy to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified." The document lists the procedure as 1. Upon notification of skin breakdown, a newly acquired skin condition report will be completed and forwarded to the Director of nursing. 2. The pressure area will be assessed and documented on the Treatment Administration Record. 3. Complete all areas of the TAR-Document the size, stage, site, depth, drainage, color, odor and treatment (upon obtaining from the physician), Document the status of the pressure ulcer, Document the color, 4. Notify the physician for treatment orders, 5. Documentation of the pressure area must occur upon identification and at least once a week on the TAR. (B)	S9999		