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S 000	Initial Comments Complaint Investigation 2471731/IL170457	S 000		
S9999	Final Observations Statement of Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)1 300.1210 d)3) 300.1210 d)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 300.1210 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	S9999		

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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:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
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 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 interventions to prevent the development of pressure sores. This failure resulted in R1 developing a Stage 3 pressure sore to her

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sacrum.

This applies to three of four residents (R1, R3 and R4) reviewed for wounds.

Findings include:

1. R1 was admitted to the facility on 9/29/2023 for rehabilitation following a bilateral hip replacement. R1 has diagnoses that includes anemia, morbid obesity, diabetes, urine retention, constipation, anxiety, congestive heart failure, muscle weakness and a history of falling. R1 was discharged from the facility on 11/05/2023.

The admission assessment, dated 9/29/2023, identified bruises on R1's left hand and right lower leg.

R1's MDS (Minimum Data Set), dated 10/05/2023, indicated she is cognitively intact. The admission assessment identified R1 as being dependent on staff for toileting hygiene, showers / bathing, dressing lower body and personal hygiene. R1 was assessed as completely dependent on staff for repositioning.

The care plan dated, 9/29/2023 documented R1 presented with decreased transfers and ADL (Activities of Daily Living) due to weakness post hospitalization. R1 is admitted with surgical wound to bilateral lower extremities post-surgical repair due to right and left intertrochanteric (hip) fracture. At risk for skin impairment related to required ADL care assist due to recent hospitalization, decreased mobility, history of diabetes and urinary incontinence. Intervention includes encourage / assist with turning / repositioning often. Monitor pressure areas for color, sensation and temperature. Monitor skin

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status with routine care and notify provider of any changes.

There was no wound or skin concern documentation for R1 prior to 10/12/2023. On 10/12/2023, a stage 3 (full thickness tissue loss) pressure sore to R1's sacral area measuring 5.50 cm x 3.50 cm x 0.10 cm (centimeters) was documented per physician's order sheet, dated 1/15/2023, "Tx: to sacral and right buttock wounds - cleanse with NS (Normal Saline), apply skin prep to peri wound area, apply cut to fit Xeroform to open wounds, cover with secondary dressing daily and as needed. Every day shift for stage 3."

PCT (Patient Care Technician) documentation for October 2023 was reviewed. Assistance to roll left and right was documented as NA 10/6/2023-10/12/2023 and 10/25/2023 on the night shift. Toileting hygiene was documented as NA 10/6/2023- 10/12/2023, 10/18, 10/19, 10/28 and 10/21/2023 on the night shift. Skin observation across three shifts in October 2023 was documented as NA for 17 shifts and no issues observed for 62 shifts. November 2023 skin observations across three shifts were documented as NA for 7 shift and no issues observed on 1 shift.

On 3/7/2024 at 3:42 PM, charting abbreviations were clarified with V2, DON. X= the task was not due at that time. NA (Not Applicable) = it did not apply to that task, and it did not occur. Blank spaces = missed charting.

On 3/6/2024 at 12:15 PM, V3, Wound Nurse, stated R1 did not have a pressure wound or MASD (Moisture Associated Skin Damage) on admission. V3 stated R1 developed a right

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buttock and sacral / coccyx MASD that progressed to a stage 2 (partial thickness loss of dermis) pressure wound. V3 stated on 9/29/2023, R1 was identified as being at risk for developing a pressure wound on admission. V3 stated on 10/2/2023, skin barrier and a protective dressing were ordered. On 10/3/2023, off-loading of heels, turn and repositioning was ordered. On 10/5/2023, an air mattress was ordered. V3 stated pressure wounds can develop overnight. V3 stated she did not document any episodes of R1 refusing care.

On 3/6/2024 at 4:10 PM, V2, DON (Director of Nursing), stated she knew of R1's facility acquired wounds through discussion. V2 stated she had no knowledge of R1 refusing care. "If (R1) had refused care, nursing would document it and report it to therapy and management." V2, DON, stated having a bilateral hip replacement as well as other risk factors put her at a higher risk of developing a pressure wound. V2 stated when a referral is submitted for a new admission, the admissions department assess patient needs and interventions prior to their arrival. Interventions are specific to each resident's needs. V2 stated she could not say what was or was not done to prevent R1's pressure wound.

On 3/7/2024 at 11:52 AM, V4 (R1's Family Member) stated she stayed overnights at the facility from 9/29/2023 to 10/11/23. V4 stated on the nights she stayed at the facility, staff looked in R1's the room, but no staff repositioned R1 or changed her undergarment. V4 stated the nurse straight catheterized R1, but did not turn her. V4 stated she did not turn or reposition R1 because she did not know that was necessary.

On 3/7/2024 at 12:24 PM, V6, RN (Registered

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Nurse), stated he worked the night shift and recalled caring for R1. V6 stated V4 (R1's Family Member) did stay overnights at the facility for a few weeks. V6 stated V4 stayed for R1's emotional support and did not provide care for R1. V6 stated R1 was not able to move independently and required staff assistance for repositioning and hygiene assistance. V4 stated on the occasions he straight catheterized R1, he did not reposition her. V6 stated the CNAs (Certified Nursing Assistants) also known as PCTs (Patient Care Technicians) would answer R1's call light. V6 stated he would not say the CNA turned R1 every two hours. "CNAs would change and turn someone who wasn't alert, but a resident like (R1), we'd just peek in on so she could get rest."

On 3/7/2024 at 11:56 AM, V5 (Wound Physician) stated he recalled R1's name, but not her care. V5 stated he did not know what caused R1 to develop her pressure wounds. V5 stated prolonged periods of not being repositioned would cause anyone to develop a pressure wound regardless of predisposing risk factors.

2. R3 was admitted to the facility on 01/21/2022. R3 has diagnoses that includes Parkinson's Disease, Alzheimer's Disease, Overactive bladder, anxiety, history Cerebral Infarction, and Major depressive disorder.

The Minimum Data Set, dated 11/25/2023, indicated R3 is cognitively impaired. R3's primary mode of transportation is a wheelchair and walker with staff assistance. R3 requires supervision to partial / moderate assistance staff assistance with Activities of Daily Living. The risk of pressure ulcer / injuries was identified. No pressure

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related issues identified at time of assessment.

R3's care plan, dated 12/20/2023, states R3 has self-care deficits and requiring assistance from staff for ADL care. R3 is at risk for skin impairments required ADL care assist due to decreased mobility.

R3's right heel pressure related redness was identified on 1/3/2024 as a stage 1 (non-blanchable redness). R3's left heel pressure ulcer was identified on 1/3/2024 as a stage 2 (partial thickness loss of dermis) measuring 0.50 cm x 0.50 cm x 0.00 cm. Skin observations by the PCT across three shifts for the January 2024 documents NA on 36 shifts and no issues observed on 53 shifts.

Skin observations by the PCT across three shifts for the February 2024 documents NA on 38 shifts and no issues observed on 42 shifts.

On 3/5/2024 at 12:42 PM, R3 stated she didn't think she had any skin wounds.

On 3/6/2024 at 9:27 AM, the dressing change to the right and left heels of R3 was observed. Both heels appeared purple but blanchable

On 3/6/2024 at 12:15 PM, V3, Wound Nurse, stated R3's pressure related skin issues were first observed on 1/3/2024. V3 stated R3 had physician orders in place for off loading her heels. V3 stated if R3's heels had been off loaded there should be no reason for her to develop heel redness. V3 stated with the foam dressings off loading is still being done. V3 stated the direct care responsibilities fall to the CNAs. The CNAs should be placing the heel protecting boots on the resident and alerting the nurse of any issues.

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3. R4 was admitted to the facility on 9/11/2017. R4's medical diagnoses includes diabetes, anemia, congestive heart failure, peripheral vascular disease, muscle weakness, dementia, and anxiety.

R4's Minimum Data Set, dated 2/11/2024, indicates resident is cognitively intact. R4 is dependent on staff assistance for toileting hygiene, showers / baths, and dressing lower body. R4 requires substantial staff assistance with repositioning left to right.

The care plan, dated 3/5/2024, stated R4 has potential for pressure ulcers related to decreased mobility, bowel and bladder incontinence as evidence by previous skin alterations.

Skin observations by the PCT across three shifts for the January 2024 documents NA on 36 shifts and no issues observed on 26 shifts.

Skin observations by the PCT across three shifts for the February 2024 documents NA on 36 shifts and no issues observed on 18 shifts.

No documentation of refusal of care was noted in progress notes. R4's current care plan does not address refusal of care related to off loading with pillows and heel boots.

R4 facility acquired stage 2 pressure wound was identified on 2/7/2024. Wound measurements 0.50 cm x 0.40 cm x 0.00 cm.

R4's physician orders in place prior to wound development includes off load back / buttocks with pillow, heels with boots and reposition when

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in bed. Turn R4 every two hours while in bed. Place R4 back to bed if she has been sitting for more than one hour.

On 3/6/2024, R4's skin was observed during her dressing change. R4's buttocks were reddened and not blanchable. R4 had a small opening to her left buttocks slightly smaller than a pea. No drainage was noted.

On 3/5/2024 at 12:37 PM, R4 stated she has a wound on her buttocks, but she did not know how she got it. R4 stated the staff change her undergarment and assist her to reposition when she calls them for assistance. R4 stated she does not call for staff assistance every two hours.

On 3/6/2024 at 12:15 PM, V3, Wound Nurse, stated other staff stated R4 has refused care.

On 3/6/2024 at 4:10 PM, V2, DON, stated R4 often refuses care, and is particular about her caregivers. V2 stated R4's pressure ulcer is related to her refusal of care.

The facility provided Policy and Procedure for Skin Checks, dated July 2018, states PCT assignment to assess patient's skin from head to toe every shift. The PCT and nurse should complete a skin check regardless of if the shower or bath is done, biweekly on shower days. All skin impairments should be documented in the task menu in POC for PCT documentation and notify the nurse immediately. The nurse should assess skin changes or concerns and document in the treatment assessment record or create an incident report. If appropriate (patient, family and physician should all be notified of any skin changes noted.

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