| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6006720 | A. BUILDING: _____ B. WING _____ | C 07/22/2021 |

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| S 000 | Initial Comments<br><br>Complaint Investigation<br><br>2174862/IL135856 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1010h)<br>300.1210b)<br>300.1210d)2)<br>300.1210d)3)<br>300.1210d)5)<br>300.3240a)<br><br>Section 300.1010 Medical Care Policies<br><br>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 of notification.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>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:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>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.<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements were not met as evidenced by: | S9999 | | |

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| S9999 | Continued From page 2<br><br>Based on interview and record review, the facility failed to ensure a resident did not experience trauma from a leg immobilizer resulting in the development of a pressure ulcer. The facility also failed to provide physician-ordered treatment to a resident's facility-acquired pressure ulcers. These failures resulted in R1 developing a Stage 4 pressure ulcer on the left lower leg requiring a vacuum-assisted wound closure device and seeking a plastic surgery consult for wound closure, and an unstageable pressure ulcer of the left ankle.<br><br>This applies to 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 6.<br><br>Findings include:<br><br>The EMR (Electronic Medical Record) shows R1 was admitted to the facility on April 9, 2021. The EMR shows R1 was discharged from the facility on June 14, 2021 to the local hospital with a diagnosis of UTI (Urinary Tract Infection). R1 did not return to the facility. R1 had multiple diagnoses including fracture of the left patella, UTI, hemiplegia and hemiparesis following cerebral infarction affecting her left non-dominant side, lack of coordination, heart disease, major depressive disorder, and cellulitis of the left lower limb.<br><br>R1's MDS (Minimum Data Set) dated April 12, 2021 shows R1 had moderate cognitive impairment, required limited assistance with eating, and extensive assistance with all other ADLs (Activities of Daily Living). R1 had functional range of motion impairment on one side of her upper and lower extremities and used a wheelchair for mobility. R1 had an indwelling | S9999 | | |

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| S9999 | Continued From page 3<br>urinary catheter and was frequently incontinent of stool. The MDS continues to show R1 was at risk for developing pressure ulcers and did not have one or more unhealed pressure ulcers at Stage 1 or higher upon admission.<br><br>R1 was transferred to the local hospital on June 14, 2021 from the facility. Hospital documentation dated June 14, 2021 shows R1 was admitted to the local hospital with an unstageable pressure ulcer to the left lateral ankle measuring 1.7 cm length x 1.5 cm. width, and a Stage 4 pressure ulcer to the left lateral lower leg measuring 4 cm. length x 2.5 cm. width x 0.5 cm. depth with tendon exposed.<br><br>Hospital documentation dated June 19, 2021 shows R1 was admitted to the hospital on June 14, 2021. "Patient completed short course of antibiotics. [R1] was also found to have several pressure ulcers/wounds including a left lower extremity Stage IV with tendon exposed. General surgery was consulted and performed bedside debridement. Plastic surgery was also consulted and recommended wound VAC placement with follow-up in several weeks to evaluate for potential skin grafting."<br><br>V5's (Registered Nurse/RN/Wound Nurse) skin assessment for R1, dated April 12, 2021 shows no open wounds. R1's skin assessment shows, "Left lower extremity removable brace. Left posterior lower leg: mild redness noted under brace. Skin intact."<br><br>On April 20, 2021 at 11:05 AM, V5 (RN/Wound Care Nurse) documented, "Note: Treatment: [R1] has a new wound to her left lateral lower extremity possibly from her brace rubbing. Wound bed is 100% red with periwound bruising. | S9999 | | |

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| S9999 | Continued From page 4<br><br>Wound noted with small sanguineous drainage. Wound bed measures 3 x 3.5 x 0.1 cm. (centimeters). Writer cleansed wound bed with NSS (Normal Saline Solution), patted dry, and applied [honey wound gel], an ABD (Abdominal gauze pad), and wrapped with [rolled gauze]."<br><br>On April 28, 2021, V6 (Wound Care Physician) documented, "Initial Assessment. [R1] is a 95 year old female that has a trauma wound on the left lateral lower leg due to the left lower leg immobilizer since 4/22/21. The patient does complain of pain 9/10 (0 is no pain, 10 is greatest pain) and has tenderness when the wound is examined and when the dressing is changed. ...Wound #1 status is open. The wound is currently classified as a full thickness without exposed support structures wound with etiology of trauma, other and is located on the left, lateral lower leg. The wound measures 4 cm length x 3 cm width x 0.2 cm depth. There is a medium amount of serous drainage noted. There is small (1-33%) pink granulation within the wound bed. There is a large (67-100%) amount of necrotic tissue within the wound bed including adherent slough..."<br><br>On April 28, 2021, V6 (Wound Care Physician) ordered wound cleansing and dressings to include, "Cleanse wound with ¼ strength Dakin's solution and then with NS (Normal Saline). Protect periwound with skin prep. Apply alginate to wound bed. Apply debriding agent to wound bed [honey gel]. Cover wound with ABD. Secure dressing with [stretch gauze]. Change daily. Change prn (as needed) for soiling and/or saturation."<br><br>A review of the EMR shows V6's orders from April 28, 2021 were not started until May 4, 2021. | S9999 | | |

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| S9999 | Continued From page 5<br><br>V6 continued to treat R1 weekly at the facility from April 28, 2021 to June 9, 2021 with continuing treatment orders. The facility does not have documentation to show R1's lower leg wound received physician-ordered wound treatment on April 24, 25, 26, 2021, May 1, 2, 8, 9, 15, 20, 21, 22, 23, 29, and 30, 2021, and June 6, 2021.<br><br>On April 29, 2021 at 6:55 AM, V5 (RN/Wound Care Nurse) documented, "Treatment: Writer spoke with [R1's] surgeon (V8) about [R1's] left lower extremity immobilizer. Surgeon gave orders that immobilizer must be on at all times during transfers and when the patient is up in her wheelchair. He said the immobilizer does not need to be on while the patient is in bed."<br><br>The EMR shows the following order dated April 28, 2021, "Per ortho recommendation, left knee immobilizer to be on when up from bed/during transfers. Off when in bed."<br><br>Nursing documentation on the April and May 2021 TARs (Treatment Administration Records) shows nursing initials acknowledging V8's order. The facility does not have documentation to show if R1's knee immobilizer was ever removed or for what period of time R1 was without the immobilizer. Prior to May 28, 2021, the facility does not have any documentation to show V8 (Orthopedic Physician) was notified of the worsening skin breakdown R1 was experiencing due to the knee immobilizer brace.<br><br>On May 19, 2021 V6 (Wound Care Physician) documented R1's left lateral lower leg wound was worsening. "The wound measures 6.5 cm. length x 3.5 cm width x 0.5 cm depth." V6 documented | S9999 | | |

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R1 developed a second wound on the left lateral malleolus (ankle) measuring "1.2 cm. length x 1.5 cm. width x 0.1 cm. depth. The wound margin is distinct with the outline attached to the wound base. There is a large (67-100%) amount of necrotic tissue within the wound bed including adherent slough." V6 also documented R1 "Has a trauma wound on the left lateral ankle due to the left lower immobilizer since 5/19/2021." V6 ordered wound care for R1's second pressure ulcer, including cleaning with Dakin's solution and normal saline, honey gel, and covering with a dressing.

The EMR shows an order dated May 21, 2021 for, "Left lateral ankle. Cleanse with NSS, apply [honey gel] and alginate with dry dressing daily."

The facility does not have documentation to show treatment to R1's left lateral ankle was completed as ordered on May 22, 23, 29, 30, and June 6, 2021.

On June 2, 2021, V6 (Wound Care Physician) documented R1's left lateral lower leg wound had "exposed tendon." V6 documented R1's left lateral ankle wound was worsening and measured 2 cm. length x 2 cm. width x 0.2 cm. depth.

On July 19, 2021 at 1:53 PM, V1 (Administrator) and V2 (Director of Nursing/DON) said it is their expectation that residents receive wound care as ordered by the physician. V1 said the facility is frequently using agency nursing staff who don't complete wound care on the weekends when the wound care nurse is not present in the facility. V2 said missed wound care treatments have been a problem at the facility. V2 also said the facility had difficulties with R1's telehealth visits during May

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| S9999 | Continued From page 7<br>2021 and several of R1's visits with V6 (Orthopedic Physician) were missed.<br><br>On July 19, 2021 at 2:56 PM V6 (Wound Care Physician) said, "[R1's] wounds were caused by trauma and pressure from the immobilizer brace. It is my expectation the facility staff administer wound care daily as I order it. I expect them to start the orders within a day or two of me placing the order. They should also have been documenting the time the brace was being removed and put back on, so we had a good idea if the pressure was being taken off the wound. [R1] did end up developing two pressure ulcers due to the immobilizer brace, and one of the wounds did end up having tendon exposed."<br><br>On July 20, 2021 at 12:22 PM, (V8) (Orthopedic Physician) said, "I was told by the facility on April 28, 2021 [R1] was developing a small wound under her brace. A small wound, such as a Stage 1 pressure ulcer is not uncommon in the elderly population while wearing an immobilizer brace, however, I expect the wound can easily be controlled and cared for by a wound care team and wound care physician. If the wound gets worse, I should be notified. The resident was supposed to follow up with us, a few weeks after April 28, 2021 via a telehealth visit. The facility never did that. Our records show four visits for [R1] during the month of May 2021 that were never logged onto via the telehealth phone number by the facility. We were never told the extent of [R1's] pressure ulcer from the brace. Had I been made aware the wound had progressed to the extent the wound did, and had the facility kept the telehealth appointments with us, I would have discontinued the immobilizer brace much sooner, and possibly avoided such a serious wound where the tendon became | S9999 | | |

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| S9999 | Continued From page 8<br>exposed. I've never seen a wound progress this bad while receiving wound care from a wound care team and a wound care physician. On June 2, 2021, I told the facility they could get rid of [R1's] brace, but still was not informed of the extent of the wound. I was never made aware the resident left the nursing home and was hospitalized. After [R1] left the facility, I saw the resident and she had a wound vac device over her wound and had a plastic surgery consult. I had given an order the facility could take the immobilizer brace off while the resident was in bed back in April. After seeing [R1's] wound, I don't see how they could have been removing the brace. They should have kept track of the amount of time the brace was off the resident and if the wound was worsening, they should have informed me."<br><br>(A) | S9999 | | |