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S 000	Initial Comments Complaint: 2185164/IL136236	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5) 300.1220b)3) 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 decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 2 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 follow their policies and ensure identification, monitoring, assessment, and treatment of a pressure ulcer for one resident (R1) out of 3 residents reviewed	S9999		

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for ulcers and failed to develop an individualized care plan for newly identified pressure ulcer of the left foot according to Physicians Orders. These failures resulted in R1 developing a left heel wound that progressed to osteomyelitis. As result of the infection, R1 could not receive a prosthesis for the right leg. This failure also resulted in the delay of R1's placement on the Renal Transplant List due to an infection and open wound on the left heel. Doctor's current prognosis is to continue treatment as a palliative heel.

Findings include:

Current Face Sheet documents R1's is a 65-year-old male admitted to the facility on 3/23/2021 and discharged on 7/5/2021. Minimum Data Sheet (MDS) dated 3/29/2021 documents R1's mental status was intact as noted in the Brief Interview for Mental Status (BIMS) score of 12 out of 15. MDS documents R1 requiring one-person physical assist with most Activities of Daily Living. Diagnoses include: Type 2 Diabetes Mellitus without complications, Acquired absence of Right leg below the knee, End Stage Renal Disease, peripheral autonomic neuropathy, Pressure ulcer of left heel, other acute Osteomyelitis, left ankle and foot, Hyperlipidemia, Essential Hypertension, Atrial Fibrillation Unsteadiness on feet, Cognitive communication deficit, peripheral vascular Disease, Pulmonary Hypertension.

During an interview with R1 on 8/3/2021 at 12:31 PM, R1 states he only had the wound from the right BKA(below the knee amputation) when he was admitted to the facility. R1's Hospital discharge records dated 3/23/2021 is absent of any mention of a left heel/foot ulcer.

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S9999	Continued From page 4 Documentation is as follows: Left foot, wash with antiseptic spray, and apply A&D Crème. Review of facility's Treatment Administration Record (TAR) documents the following Physician order: to start on 3/24/2021: Vitamin A & D Ointment (house stock)/ABD/Kerlix/ACE wrap every day shift every other day for preventive measures. Left Lower Leg: NSS Cleanse. Pat dry. Apply Vitamin A&D ointment. Abdominal pad on the heel. Kerlix wrap. Secure with tubigrip. V15 (Physician Assistant) progress note dated 3/25/2021 documents the following: Major rehabilitation goals: Return to pre-morbid functional status of independence for ADLs, transfers, speech/cognition, independence for swallowing. Goals for ambulation currently are only pre-prosthetic training. Once he gets a prosthesis, ambulation goals will be added. V15 (PA/Physician Assistant) Progress notes dated 4/13/2021 documents the following: Indications for rehabilitation: The patient needs to be assessed for deep vein thrombosis, skin breakdown, any change in mental condition, sepsis, respiratory failure, and cardiopulmonary decompensation. On 8/6/2021 at 3:21 PM V15 (PA/Physician Assistant) states he was consulting for rehab. Goals for rehab were to allow transfer in and out wheelchair. Goal: prosthetic fitting and training. Complication developed with left leg so focused on transfers, bed mobility, and ADLs. The left leg wound inhibited therapy. Resident became non-weight bearing. Initially much more functionality noted. The facility had to stop because R1 became	S9999		

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non-weight bearing on the left leg because of the heel wound. R1 needed to be weight bearing on the left leg to be fitted for the right leg prosthetic and for prosthetic

On 8/03/2021, R1 states that two weeks after being in the facility, R1 found a wound on his left heel and V6 (Wound care nurse) wrapped it for him that day. R1 states every day after that for 1 week and 3 days, he went to the front desk to ask staff to change his dressing on the left heel. They would say, "I will send someone. I will send the wound care nurse, but no one came for 1 week and 3 days." After this time, V6 came to room and changed the bandage. R1 states V6 (Wound Nurse) saw the drainage that had leaked through the dressing. V6 began squeezing the area, believing it was a blister. R1 stated "I told him to stop squeezing it because it hurt too bad to be a blister. I told V6 I was going to go see my wound care doctor on Monday, and I made an appointment." After being diagnosed with Osteomyelitis, R1 states it made him feel really bad that he cannot receive his prosthesis and was taken off the renal transplant list. R1 stated " I thought I was going to be walking when I left the facility. They were going to make my prosthetic while I was at the facility, and I would come home with it. It's a double shot. I have no prosthetic and not I'm not able to get on a transplant list because of this. I thought I would be walking, and I can't do it now. It was the end of April/beginning of May that I went to see the wound doctor."

During an interview with V11 (Podiatrist/Wound Care Clinic) on 8/4/2021 at 1:15 PM, surveyor read the above order, regarding application of Vitamin A&D ointment, to V11. V11 stated that the treatment read to him was not wound care

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treatment, it was an order for moisturizing the area. V11 stated "If the facility is doing daily dressing changes and they see a wound and do nothing, that is not right. They need to work up the wound, do culture tests, apply wound care products, have x-ray done and more. "

On 8/5/2021 3:59 - 4:19 PM ,V11 stated "The goal now that the wound is open and chronic and blood flow is not best, we want to keep the wound infection free. This is more of a palliative heel. Two weeks ago we looked up a super-specialist to see if they can vascularize his foot to salvage what he has. We have been trying everything on it, IV and Oral antibiotics . We are trying antibiotic via graft/mesh to minimize the side effects with chronic oral and IV antibiotic use.

V11 (Podiatrist) note dated 4/26/2021 documents "V11 performed sharp excisional debridement of left heel lateral aspect ulcer."

The following is on physician order sheet dated 4/26/2021 but does not appear on R1's Treatment Administration Record (TAR),: Left heel-Iodosorb, cover with non-adherent contact layer, gauze, roll gauze and tape. Ace wrap to left lower leg. Change dressing every other day and PRN. Offload heel always, use Prevalon boot or equivalent.

On 8/11/2021 at 9:45 AM, V3 (DON) states "Someone has to physically put an order in the TAR. The wound care nurses are responsible for transcribing the order into the TAR. The wound care nurses do it for the most part. Floor nurses can put the orders on the TAR, if they are capable of doing it. Wound care nurse checks for orders daily. They can do their own listing report to

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select new orders. If the resident went to an appointment, the wound care nurse will follow up to see if there are any orders. That is my expectation." Surveyor asked V3 to explain how a Doctor's order could not make it onto the TAR. can you explain how a doctor's order does not make it to the TAR. V3 replied, " It can happen if it's not put in the usual way, or a honest mistake."

The first document of R1's wound in the nurses progress notes are from V9 (RN) Health status note dated 4/26/2021. Documents the following: "Received a call from V12 (RN Wound Center) and told NOD (nurse on duty) that resident came to wound center at the Hospital after his hemodialysis treatment due to left foot blister. Wound care team made aware and Primary Care MD made aware and okay with consult."

On 8/4/2021 at 10:08 AM, V9 confirms he wrote the above note. V9 states he does not remember R1 having any wounds other than the wound on the right stump. On 8/4/2021 at 4:22 PM, V12 (RN, Wound Care Clinic) states the first time R1 was seen by them, after the right leg below the knee amputation (BKA), was on 4/26/2021. V12 states he believes R1 called to make the appointment and R1 was seen weekly after 4/26/2021.

The first documentation of an issue with R1's left foot is from a Shower sheet dated 4/22/2021. There is a scribble (unclear writing) notation regarding area of the ankle on the left foot.

Physical Therapy note dated 5/6/2021 (service dates 4/30/2021 - 5/6/201) documents for the first time the identification of R1's left foot wound and the precaution to off load. No documented wound assessment to the left heel wound was

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S9999	Continued From page 8 done during that week nor was update to care plan done. There are no orders transcribed to R1's TAR for the left heel/foot wound are until 5/19/2021. even though wound was identified and debrided by V11 on 4/26/2021. The first documentation of R1's left heel wound by a wound care nurse was on the Weekly wound assessments dated 5/16/2021 by V6 (Wound Nurse). Physician order sheets documents, R1 orders for Vancomycin intravenously and Ceftazidime intravenously on Mondays, Wednesdays and Fridays to start on 6/19/2021 " for Osteomyelitis/ulcer of left heel." On 8/4/2021 at 1:30 PM , V4 (Regional Nurse Consultant) hands surveyor a stack of Wound Assessment Details Reports and states that the left lateral heel wound was identified on 5/16/2021 and that V6 put the date identified on the form as 3/23/21. The correct date wound was identified is 5/16/2021. On 8/4/2021 at 11:20 AM V6 (Wound Care Nurse) states he did not learn of the wound until 6/1/2021 when the resident came from the podiatrist with orders. Review of all wound assessment sheets from 3/24/2021 until the 5/16/21 assessment is absent of any mention the left heel/foot wound. Review of resident's Care plan reveals no update to reflect a plan of care for left heel wound that was identified by the facility on 5/16/2021.	S9999		

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S9999	Continued From page 9 5/16/2021 Wound Assessment details report done by V6 documents: Full thickness wound to left lateral Heel. 20% pink or red tissue, 80% slough non-adherent with scant serous exudate. Review of all of R1's TAR's document nurses signing off on the TAR that the above treatments were done every other day from 3/24/2021 through 6/10/2021 (except 3 days in April [3rd, 15th, and 25th]) and confirmed by nurses Interviews: On 8/4/2021 at 12:17 PM, V8 (LPN) states "I remember R1 but not that much. I don't remember anything about R1 heel/foot wound." Surveyor showed V8 her initials on R1's TAR and R1 states she signed, but she did not do the treatment. V8 states she referred treatment to the wound nurse. V8 signed off on it but did not do the treatment. V8 reported to V5(Wound Care Nurse) that it needed to be done. V8 is unsure whether the treatment is then completed. Surveyor showed her the TAR for April 2021. V8 stated every time there was a wound care to be done, it was reported to the wound care nurse to be completed. She signed off, but did not complete the treatment. V8 never confirmed the treatments were completed. Surveyor showed V8 the TAR in May with Santyl order. V8 (LPN) stated, "I believe all nurses do the same thing. I never see the wound because I don't change the dressing." Surveyor asks V8 who directed her to sign the TAR and then ask the wound care nurse to do the treatment. V8 states she learned it from working at the facility. That is how it is done. Surveyor asks if she follows up with wound care to see if treatment was done and V8 said "no." Surveyor asks if V8 does daily skin assessments. V8 states "No, the wound care nurse does it weekly."	S9999		

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S9999	Continued From page 10 On 8/4/2021 at 12:40 PM, V9 (RN) states, "The wound care nurse does the wound treatments. We just sign off on it. This is the practice of all the nurses." Surveyor showed V9 his initials on R1's TAR and V9 said he signs off and the wound nurse does the treatments. Review of the TARs for R1 from admission to discharge has the initials of multiple nurses including the V8, V9, and V13 who stated they did not do treatments. On 8/5/2021 at 10:11 AM, V13 (Former RN) states., "The wound treatment nurse would use their own computer to sign off for wound treatments they provided to the resident. I'm not sure how they process it on their side. Once I click the TAR, I would inform the wound care nurse that they needed a treatment. It is the policy and practice of the facility to sign off on the TAR and inform wound care nurse." V13 states direction to do it that way came from management. V13 said, "I learned it in orientation. I don't remember exactly who told me to do it that way." On 8/5/2021 at 5:39 PM V6 (Wound Care Nurse) asks the process for completing wound treatments. V6 states he has a computer. V6 said, "I go to the TAR, the TAR tells me the treatment to do. I go to patient name and it shows treatment. Usually, it is yellow before I do it. After I do the treatment, I check it and it turns green." V6 said, "Sometimes the nurse signs it, but they ask me if I did it first, then they sign it." Surveyor asks V6 of he also assesses everyone who is not listed as having wounds. V6 stated, "Yes, on admission we do skin assessment. We just treat once a resident is diagnosed with a	S9999		

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wound. We do weekly wound assessment and document in wound rounds."

Wound care treatment and computer process observed by surveyor on 8/4/2021 at 10:24 AM with V7 (Wound Care Nurse , PRN).

On 8/5/2021 at 1:09 PM, the surveyor asks V2 (ADON), if the nurse signs the TAR then who does the treatment? V2 said, "Wound treatments are done by the wound care nurse." Surveyor clarified, If V8 (Nurse) signs the TAR, the wound care nurse does the treatment? V2 said, "The wound care nurse does the treatment. It is not actually our policy. It is our practice. The nurse asks the wound care nurse if it is done, then the nurse signs off that it was done. Surveyor inquires who instructs the nurses to sign TAR on something they did not do? V2 stated, "It is ensuring documentation is done." The nurses sees wound care nurse and ask if it is done and then the nurse signs off that it was done. Surveyor asks V2 if there is knowledge that the nurses are signing the wound treatment off, then alerting the Wound Care Nurses to complete? V2 said, "There are no ~~instruc~~tions. That is our practice. We sign off if treatment is done by wound care."

On 8/17/2021 at 1:39 PM V26 (Renal office RN) states R1 is not on the transplant list because they are waiting for the wound to heal. Getting on the list was put on hold because of infection. There can be no open wounds before the evaluation

On 8/17/2021 at 1:42 PM V24 (Social Worker) and V25 (Renal Doctor) states the goal for R1 was to rehab at the nursing home then do the transplant work up to get on the transplant list.

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S9999	Continued From page 12 R1 got an infection in the left heel, so he is no longer on the transplant list at this time. Braden Scale Assessment is a predictor of pressure ulcer risk. R1's Braden score on admission dated 3/23/2021 documents a score of 20. A score of 20 is considered high risk. Facility's wound care program care guidelines dated 7/3/2019 documents the following: The goal of this policy is to achieve compliance to regulatory requirements and provide evidence-based recommendations for the prevention and treatment of pressure ulcers that can be used by the health professionals in the facility. The purpose of the prevention recommendations is to guide evidence-based care to prevent development of pressure ulcers and the purpose of the treatment focused recommendations is to provide evidence-based guidance on the most effective strategies to promote pressure injury/ulcer healing. Procedures: Timely identification of residents assessed to be at risk for skin breakdown. Each risk factor and potential cause (s) identified should be reviewed individually and addressed into the resident's care plan. Proper Identification of Risk factors that can impact in the development of unavoidable ulcer or may impede with the healing process if resident does have an ulcer. The following are the risk factors for review: Contractures, decreased mobility or Bedfast, Diagnosis of Diabetes/Thyroid Disease, Parkinson's, End stage disease/terminal illness, History of Pressure injuries, Recent Surgery/Hospitalization, Renal dialysis. Prevention of skin bread includes but not limited to; Inspection of the skin every shift with care for signs of breakdown. Moisturize	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006662	A. BUILDING: _____ B. WING _____	C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 skin with lotion to keep the skin soft and pliable. Documentation a. Wound Rounds system - using phone device connected to the internet that allows nursing staff to effectively evaluate, monitor, tract and treat residents and/or patients at risk for pressure ulcers while providing one-step wound assessment documentation. The care plan shall be evaluated and revised based on resident's response to treatment; treatment goals and outcomes. The resident's skin alteration/breakdown (pressure ulcer, arterial, diabetic, venous ulcers and etc ...) shall be documented in the clinical records in accordance to the facility's policy and in compliance to current regulatory standards. Pressure Ulcer Treatment: Initiate wound care treatment upon identification of the wound with physicians order. Develop a care plan with appropriate interventions. Timely referral to facility's Wound Care Specialist for State III/IV pressure ulcers and/or any recalcitrant wounds. Quality Assurance and Performance Improvement. The facility may utilize the QAPI Process for implementing skin and wound care program. (A)	S9999		