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 |
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| | IL6005938 | A. BUILDING: ______ B. WING ______ | C 02/01/2022 |

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| LOFT REHAB OF DECATUR | 500 WEST MCKINLEY AVENUE DECATUR, IL 62526 |

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| S 000 | Initial Comments<br><br>Complaint Investigations:<br>2260550/IL142703<br>2260556/IL142705<br>2260903/IL143125 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>(1 of 3)<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)3)5)<br>300.1220b)2)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b)The facility shall provide the necessary care | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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

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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 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:
2)Overseeing the comprehensive assessment of

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the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

These Requirements were Not Met evidenced by:

These Failures require more than one deficient practice statement.

A. Based on observation, interview, and record review, the facility failed to monitor, observe, assess, notify and implement targeted interventions to prevent the development and or worsening of unstageable pressure ulcers for one of four resident (R6) reviewed for pressure ulcers. These failures include lack of: skin assessment/checks, pressure wound monitoring, repositioning assistance, incontinence care assistance, transfer assistance, for a resident who required extensive assistance. This failure affects one of four residents (R6) reviewed for pressure ulcers. R6 developed two additional unstageable pressure ulcers between 12/31/2021 (readmission) and 1/25/2022.

Findings include:

The facility's policy, with a revision date of 12-1-2020, titled "Pressure Injury Prevention and Management" documents, "Policy: this facility is committed to the prevention of avoidable pressure injuries and the promotion of healing existing pressure injuries. Definitions: "Pressure Ulcer/Injury": refers to localized damage to the skin and/or underlying soft tissue usually over a

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| S9999 | Continued From page 3<br>bony prominence. "Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with the residents needs, resident goals, and professional standards of practice; monitor and evaluate the impact of interventions; or revise the interventions as appropriate. Policy Explanation and Compliance Guidance: 2- The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3- Assessment of Pressure Injury Risk: c- Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, after any newly identified pressure injury. Findings will be documented in the medical record. d- Assessments of pressure injuries will be performed by a licensed nurse, and documented on the (fill in the blank for designated form- not filled in). The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. 4: Interventions for Prevention and to Promote Healing: a- after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b- Interventions will be based on specific factors identified in the risk assessment, skin assessments and any pressure injury assessment (e.g: moisture management, impaired mobility, nutritional deficit, staging, wound characteristics.) c- Evidence-based | S9999 | | |

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| S9999 | Continued From page 4<br>interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i- Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc), ii- Minimize exposure to moisture and keep skin clean, especially of fecal contamination, iii- Provide appropriate pressure redistributing support surfaces. iv- Maintain or improve nutrition and hydration status. 5: Monitoring, a- The Nurse Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. b- The attending physician will be notified of: i- The presence of a new pressure injury upon identification, ii- The progression towards healing, or lack of healing, of any pressure injuries weekly."<br><br>R6's Admission assessment form dated 12/21/2021, documents, Skin: Site- Coccyx: scar, (there are no measurements documented). R6's Admission assessment does not document any other skin concerns/or pressure ulcers present.<br><br>R6's medical record documents on 12/22/2021 at 2:24 AM, Skin: has old scar on coccyx, no open areas noted.<br><br>R6's medical record documents a physicians order to Cleanse left heel with normal saline, pat dry. Paint with betadine twice a day, every shift for wound care, dated 12/22/2021.<br><br>R6's medical record documents on 12/29/2021, Resident was working with therapy and eyes rolled back to head and unresponsive. Was sent | S9999 | | |

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to (local hospital) for evaluation and treatment.

R6's (Readmission assessment) form dated 12/31/2021, Skin: Site: Left heel, Type: Pressure. the Length, Width, Depth and Stage columns are blank.

R6's medical record does not document wound monitoring/assessments to include the measurements and/or characteristics of R6's Left heel (Deep Tissue Injury) pressure ulcer from 12/21/2021 (original admission) through 12/29/21 (discharge to hospital) and 12/31/2021 (readmission) through 1/25/2022.

R6's Treatment Administration Records dated January 2022 do not document the completion of physician ordered treatment of "Cleanse left heel with normal saline, pat dry. Paint with betadine twice a day, every shift for wound care" on days (6 AM to 6 PM) on 1/8/2022, 1/10/2022, 1/11/2022, 1/17/2022, 1/20/2022, 1/21/2022 and 1/22/2022.

R6's medical record documents on 1/10/2022, "complaints of pain when wiping due to pressure wound on right buttocks."

There is no documentation of the type, size or characteristics of the pressure wound located on R6's right buttocks from 1/10/2022, until 1/16/2022. There is also no physician notification documented until 1/16/2022.

R6's medical record documents "Skin Observation Tool: date 1/16/2022, Site: Right Buttock, Type: Other- Unstageable Deep Tissue Injury, Length: 7 centimeters, Width: 5 centimeters, Depth: 0.1 centimeters, Stage: Unstageable. This same form documents the

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definition of Unstageable as: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed."

R6's medical record documents on 1/20/22 at 6:45PM by V19 Registered Dietician, "Wound status reviewed. Noted resident with an unstageable DTI to his right buttock. Recommendation for Liquid Protein three times a day and Multivitamin sent on 1/18/22 for approval by (physician)."

The facility's Dietary Recommendation/Follow up form documents, "Date: 1/18/22, R6, Recommedations: Liquid Protein three times a day and Multivitamin for Unstageable Deep Tissue Injury, signed by V19. "Responses" section and "Attending Physicians signature line" were blank.

On 1/26/2022 at 1:30 PM, V5 Wound nurse stated, "I found a new area to (R6's) right heel yesterday. It is an unstageable deep tissue injury. It is on the right lateral outer ankle, it measured 3 centimeters by 4.5 centimeters. R6's left heel wound measured 9 cm by 7 cm. V5 stated, I have not found documentation regarding the dietician's recommendation (from 1/18/2022) was followed through with, (R6) is not currently receiving the recommended dietary supplements for wound healing."

On 1/26/2022 at 11:25 AM, R6's left buttock/sacral wound was approximately golf ball in size, asymmetrical with beefy red tissue noted inside the wound from approximately 9:00 to 12:00, there was obvious depth to the wound, there was also dry yellow/brown slough observed from approximately 12:00 to 6:00. Directly below

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was an additional open area with a beefy red center, half-moon shaped approximately 2 cm by 2 cm in size. R6 moaned loudly during the cleansing of the wounds to the left buttock. R6 had dry black hard eschar covering the entire bottom of the left foot proceeding upwards on the back of the heel. R6 had dry black hard eschar covering the right lateral outer ankle/heel area.

On 1/27/2022 at 1:35 PM, V5 Wound Nurse stated, R6 admitted on 12-21-21 with an Unstageable Deep Tissue Injury to the Left heel, I saw the wound and it was hard black eschar tissue, it covered the entire heel, it was an Unstageable Deep Tissue Injury, I do not see any measurements or assessment with wound description in R6's medical record. On 1-16-22 R6 was found to have an Unstageable DTI to the left buttock, we have been documenting the area was on the right buttock but it has always been on the left buttock. The wound doctor was notified of the area to the left buttock on 1-16-22. R6 is incontinent of bowel and bladder, R6 needs assistance with transferring, bed mobility, and incontinence care. Since R6 was at risk for skin breakdown and admitted with a pressure ulcer to the left heel R6 should have had at least weekly body audits being completed.

R6's care plan, created on 12/22/2021 documents, "Focus: I am at risk for alteration in skin integrity related to left metacarpal fractures, gout, hypertension, history of falls, thyroid nodule and schizophrenia, has Deep Tissue Injury to left heel Interventions: Encourage resident to reposition as needed, provide preventative skin care routinely and as needed, skin audits as ordered, treatment to left heel as ordered."

R6's additional care plan, created on 1/15/2022

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documents, "Focus: Has actual Deep Tissue Necrosis to left heel, has an unstageable Deep Tissue Injury to right buttock. Interventions: Follow physician treatment orders, (Pressure reducing boots) on as resident allows/tolerates, resident needs (pressure relieving/reducing mattress, pillows, sheepskin padding etc) to protect skin while up in chair, Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations."

R6's medical record does not document the completion of complete skin/body audits by licensed nursing staff between 12/31/2021 (readmission) through 1/25/2022.

On 1/25/2022 at 1:30 PM, R6 was lying in bed with non skid slipper socks on bilateral feet. R6 had a cast covering R6's entire hand/wrist/arm area. There was a blue (pressure reducing) boot and pink foam heel pressure reducing device noted in R6's room on top of cart. R6 stated, "yes I have a sore on my butt and my heel. I'm supposed to wear a boot."

On 1/26/2022 at 8:15 AM, R6 was lying in bed, breakfast tray on over the bed table, eating breakfast. R6 was wearing non skid slipper socks to bilateral feet, R6 stated, "I am not wearing my boot, R6 pointed to the cart in the room and stated see it is over there, they didn't put it on. There was a blue pressure reducing boot and pink foam heel pressure reducing device on a stand in R6's room."

On 1/25/2022 at 1:50 PM, V5 Wound Nurse stated, "Body audits are to be completed by Licensed Nursing staff weekly, they initial off on

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the Treatment Administration Record and will document on the skin observation tool if a new area is identified. (R6) is compliant with wearing the boot, (R6) should be wearing (pressure reducing boot)."

R6's Minimum Data Set assessment dated 1/6/2022 documents R6 requires extensive assistance of 2 or more staff members for bed mobility, transfers, toilet use and total dependence of two or more staff members for bathing, and always incontinent of bowel and bladder. This same MDS documents R6 has a current pressure injury and is at risk for pressure injuries/ulcers. This assessment also documents R6 has "1" Unstageable pressure injury presenting as a deep tissue injury. Turning and Repositioning program and Nutritional or Hydration intervention to manage skin problem documents "NO."

R6's task forms do not document assistance was provided or conducted 1/7/2022 through 1/17/2022 with bathing, transfers, bed mobility, bowel and bladder elimination and skin observations.

R6's Physical Therapy Plan of Care notes dated 1-2-2022 document, "Reason for referral: receiving skilled Physical Therapy for rehab to home after a fall resulting in left finger fractures. Patient continues to demonstrate decreased functional activity intolerance due to early onset fatigue, required extensive assistance to transition to different positions due to generalized weakness and limited use of left upper extremity and total dependence in functional transfers and gait due to impaired balance and weight bearing tolerance. Functional deficits current level: Bed mobility, rolling side to side: dependent 100

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percent assist. Bed mobility, bridging/scooting: dependent 100 percent assist. Bed mobility, supine to sit: dependent 100 percent assist. Bed mobility, sit to supine: dependent 100 percent assist.

On 1/31/22 at 9:30 AM V2 DON stated dietary recommendations are given to myself, V5 Wound Nurse and I think V1 Administrator, I then forward them to the physicians, if a response is not received from the physician within 5 days I follow back up with a phone call, etc. We did not follow back up on R6's dietary recommendation until 1/28/22. V2 stated it should have been followed up with sooner.

R6's medical record documents on 1/28/2022 12:11 PM, Resident was seen by the wound (physican) V8 on wound rounds today. Resident received new orders for a wound vac (negative pressure wound therapy).

R6's Initial Wound Evaluation and Management Summary form dated 1/28/2022, completed by V8 Wound Physician documents, "Chief Complaint: This patient has multiple wounds. Exam: Peripheral Vascular: Examination of left and right lower extremities: foot cool, wound present, mild edema. Pedal pulses left and right: Dorsalis Pedis detected by portable doppler, Posterior Tibial detected by portable doppler. Back, buttock, left lower extremity and right lower extremity: wound present. Focused Wound Exam (site 1): Arterial Wound of the Right Heel Full Thickness: Wound size: 2.5 centimeters (length) by 5 cm (width). 100 percent thick adherent black necrotic tissue (eshar). Focused Wound Exam (site 2): 9 cm (length) by 8.5 cm (width), 100 percent thick adherent black necrotic tissue (eschar). Focused Wound Exam (site 3): Stage Four Pressure

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Wound Sacrum Full Thickness, Etiology: Pressure, Wound size: 3.5 cm (length) by 4.5 cm (width) by 2.5 cm (depth). Surface area: 15.75 cm. Undermining: 4.5 cm at 3:00. Exudate: Moderate Serous. Thick adherent devitalized necrotic tissue: 20 percent, Slough: 20 percent, Other viable tissue: 60 percent (muscle, bone). Recommendations: Float heels off bed, Off-load wound, Reposition per facility protocol, Turn side to side and front to back in bed every one to two hours if able, group two mattress."

On 2/1/22 at 1:30 PM V8 Wound Physician stated, I diagnosed R6's heel wounds as arterial, R6's feet were cool to touch, non palpable pulses (detected with doppler) and the appearance of the wounds, given the fact of being told it had not gotten worse since it was first identified. All areas are pressure, someone with diabetes or circulation problems are more susceptible to breakdown, less pressure is required for this to occur. Nutritional interventions should be started when wounds are identified. Routine weekly wound monitoring should be occurring. From what I was told by V5 was R6's pressure to the buttocks started out as superficial, if repositioning is not occurring that will contribute, could have been a combination of all.

B. Based on observation, interview, and record review, the facility failed to assess and implement interventions to prevent the development and worsening of pressure ulcers in two of three (R7, R8) residents reviewed for pressure ulcers.

Findings include:

1.b. R7's medical record documents an admission date of 12/29/21.

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R7's medical record documents on 12/29/2021 at 2:29 PM, Resident arrived at facility, full code, alert and orientated times 3 not situation, hard of hearing, bed bound, poor sitting balance, puree diet thin liquids, needs to be fed, was bed bound at hospital, has poor sitting balance, is incontinent of bowel and bladder, she has wound to her buttock.

R7's Braden risk assessment form dated 1/4/2022 documents a score of 12, indicating R7 is at high risk for skin breakdown.

On 1/25/22 at 2:00 PM V5 Wound Nurse stated, R7 admitted with diaper dermatitis to her buttocks, she was at risk for skin breakdown. She was being seen by the wound physician. On 1/5/2022 she developed a Unstageable Deep Tissue Injury, I don't know what caused the area, she didn't have a special mattress before she got the area.

R7's care plan, with a creation and initiation date of 12/29/2021 documents, "Focus: (R7) is at risk for skin breakdown related to asthma, congestive heart failure, hypertension, gastroesophageal reflux, schizoaffective disorder, diabetes mellitus, spinal stenosis and history of stroke. Interventions: Encourage, ensure and assist me with repositioning every routinely (initiation date: 12/29/21), Keep me clean and dry as possible (initiation date: 12/29/21), Maintain adequate nutrition and hydration (initiation date: 12/29/21), Provide incontinence care after each incontinent episode (initiation date: 12/29/21), Provide me with any and all treatment/ dressings if ordered by my physician (initiation date: 12/29/21)."

R7's Wound Evaluation and Management Summary form dated 12/30/21, signed by V8

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Wound Physician documents, "Chief Complaint: patient has a rash. Exam: buttocks/groin: irritated dermatitis. Diagnosis: Diaper Dermatitis."

R7's Wound Evaluation and Management Summary form dated 1/5/2022, signed by V8 (Primary Wound Physician) documents, "Patient presents with a wound on her sacrum. She has an unstageable DTI sacrum for at least 1 days duration. Exam skin: buttock/groin: Irritated Dermatitis. Focused Wound Exam (site 1): Unstageable Deep Tissue Injury Sacrum Full Thickness. Etiology: pressure. Wound size: 3.1 cm (length) by 0.9 cm (width) by 0.2 cm (depth), Surface area: 2.79 square centimeter, Exudate: Moderate Serous, 20 percent: Thick adherent devitalized necrotic tissue, 20 percent: slough, 60 percent: granulation tissue. Recommendations: off load wound, reposition per facility protocol, turn side to side in bed every one to two hours if able, group two mattress."

R7's Wound Evaluation and Management Summary form dated 1/10/22, signed by V9 Wound Physician documents, "Focused Wound Exam (site 1): Unstageable Deep Tissue Injury Sacrum Full Thickness, Etiology: Pressure, Duration: greater than 6 days, Wound Size: 3 cm by 1 cm by 0.2 cm, surface area: 3.00 cm2, 70 percent thick adherent devitalized necrotic tissue, wound progress: deteriorated. Focused Wound Exam (site 2): Stage 2 Pressure Wound of the Right Buttock partial thickness, etiology: pressure, duration: greater than one day, Wound size: 2.3 cm by 6 cm by 0.1 cm, surface area: 13.80 cm2."

R7's Wound Evaluation and Management Summary form dated 1/17/22, signed by V10 Wound Physician documents, "Focused Wound

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Exam (site 1): Stage 4 Pressure Wound Sacrum Full Thickness, Etiology: Pressure, Stage: 3, Duration: greater than 14 days, Wound size: 2.5 cm by 1.5 cm. Surface area: 3.75 cm2. 100 percent thick adherent devitalized necrotic tissue, Wound Progress: deteriorated. Focused Wound Exam (site 2); Etiology: pressure, Duration: greater than 8 days, Wound size: 0.5 cm by 0.4 cm by 0.2 cm. Other diagnosis: Diaper Dermatitis resolved on 1/17/2022."

R7's Physical Therapy plan of care notes dated 12/30/21 document R7 requires moderate to maximum assist with bed mobility and on 1-9-22 maximum assist with bed mobility.

R7's Minimum Data Set assessment dated 1/5/2022 documents R7 requires assistance of 2 or more staff members for bed mobility, transfers, toilet use and bathing, and occasionally incontinent of bladder and always incontinent of bowel. This same MDS documents R7 has a current pressure injury and is at risk for pressure injuries/ulcers. This assessment also documents R7 has "1" Unstageable pressure injury presenting as a deep tissue injury. Turning and Repositioning program and Nutritional or Hydration intervention to manage skin problem documents "NO."

R7's medical record documents on 1/17/2022, "Resident was seen by wound (physician) on wound rounds. Resident wound to sacrum deteriorated, wound to right buttock improved. Resident son called with update on wound, son concerned that resident is not getting up out of bed, not walking and not being concerned about her own health."

R7's task forms do not document assistance was

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provided or conducted 1/5/2022 through 1/15/22 with bed mobility and transfers.

R7's Wound Evaluation and Management Summary form dated 1/28/22, signed by V8 (Primary Wound Physician) documents, "Focused Wound Exam (site 1): Stage 4 Pressure Wound Sacrum Full Thickness, Etiology: Pressure, Duration: greater than 23 days, Wound size: 2 cm by 1 cm by 0.4 cm. Focused Wound Exam (site 2): Stage 3 Pressure Wound of the Right buttock, resolved on 1/28/2022."

R7's care plan, with a creation and initiation date of 1/24/2022, documents, "Focus: The resident has actual impairment to skin integrity of the right buttocks/sacrum."

On 1/27/22 at 10:00 AM V5 Wound Nurse confirmed R7's care plan was not developed for R7's open pressure areas to the sacrum and buttocks until 1/24/22.

On 1/26/22 at 3:00 PM, R7 had an open area (slit like appearance) to the sacrum area approximately 2 cm by 1 cm, the area had yellow slough covering the center of the wound bed. R7 did not have any visible open areas on the right buttock, there was scar tissue noted to the right buttock.

R7's Dietary Recommendation/Follow Up form documents, "date: 1-6-22, R7, Recommendations: Add pro-stat (liquid protein) twice a day and Multivitamin for wound healing, signed by V19 Registered Dietician, Responses: blank. Attending Physicians signature of V29 (Physician) is documented."

R7's Dietary Recommendation/Follow Up form

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documents, "date: 1-18-22, R7, Recommendations: pro-stat twice a day and Multivitamin for wound healing, signed by V19 Registered Dietician, Responses: blank, Attending Physician signature: blank."

On 1-31-22 at 10:40 AM V2 DON stated, "V19 Registered Dietitian had a recommendation for pro-stat and multivitamin for wound healing. The physician returned the recommendation dated 1-6-22 and had approved, the order was never carried through. V19 evaluated (R7) again on 1-18-22, since the recommendation wasn't back and sent another rec back to the physician. (R7) has no current order and is not receiving the pro-stat."

2.b. R8's progress note printed 1/25/21 includes the following diagnoses: Diabetes, Urinary incontinence, Chronic Obstructive Pulmonary Disease, closed fracture left tibia. R1's hospital record dated 11/21/21 through 11/26/21 document R8 was admitted to the hospital during that time for acute pneumonia.

R8's Admission/Readmission Assessment dated 11/26/21 at 5:18PM documents R8 has "Strong Pulses, No Edema, and No Unhealed Pressure Ulcers."

R8's Progress Note dated 11/28/21 documents R8 has a new Deep Tissue Injury to her Left heel. No measurements documented. R8's progress note dated 12/1/21 at 2:39AM documents "Deep tissue injury remains intact to Left heel." No measurements or assessment documented. R8's Wound-Weekly Observation dated 12/2/21 documents a "Facility Acquired Assessment 37 centimeter by 4 centimeter fluid filled blister.

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| S9999 | Continued From page 17<br>Betadine twice daily." On 1/27/22 at 10:00AM V5, Wound Nurse stated "the note should have read 3.7 centimeters by 4 centimeters".<br><br>The first wound physician documentation is dated 12/8/21. V8, wound Physician classified the left heel wound as a unstageable pressure ulcer of the left heel and documents it has a 4.4 centimeter surface area. V8 plan of care includes "Elevate legs. Float heels in bed. offload wound. Reposition per facility Protocol. Turn side to side and front to back every one to two hours if able, and prevention boots.<br><br>1/26/22 at 12:30PM R8 was in bed lying on her back. R8 did not have prevetnion boots, and heel protectors in place. R8's blanket was wrapped tightly over feet and ankles and tucked under the mattress. 1/26/22 at 2:00PM R8 was lying on her back. She had soft heel protectors to both feet, but her heels were not on a pillow. V5 wound nurse removed the heel protector from R8's left foot. R8 had a round unstageable pressure ulcer to her left heel with a dime size black center. There was no dressing present to the area.<br><br>R8's January Treatment Administration Record (TAR) includes an active physician's order initiated 1/19/22 to "Cleanse left heel with normal saline or wound cleanser. Pat dry. Apply collagen sheet with silver. Cover with border gauze dressing daily and PRN (as needed). The dressing is not initialed as completed 1/20/22,1/21/22,1/22/22,or 1/25/22.<br><br>On 1/26/22 at 2:30PM V5 wound nurse stated "The floor nurse should be doing the wound dressings. I do wound assessments and round with the wound doctor. The floor nurse also does | S9999 | | |

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the weekly skin audits. They initial they are done on the TAR, but I am not sure where they document what they see." R8's January TAR includes an active physician's order initiated 12/8/21 for "Daily skin checks every day shift." These skin checks are not initialed as completed 1/20/22,1/21/22, or 1/22/22. There is no documentation R8 has been assessed by the dietitian for wound healing. R8's January MAR does not include a multiple vitamin, zinc, or a protein supplement.

R8's progress note dated 1/30/2022 at 5:23PM documents "Skin assessment completed on 1/28/22. Bilateral breast underneath slightly red, abdominal folds also red, with small areas open, treatment in place for yeast. New area noted on left calf area, that lines up exactly with pressure reduction boot. Area is not open. 1.8 (centimeters) x 1.8 (centimeters). Discolored. Treatment initiated. Will update wound MD (Physician) to review. Family notified. All questions answered."

On 1/31/22 at 10:00AM V2, Director of Nursing stated "We did skin sweeps over the weekend and (R8) has area on her left lower leg. We have a treatment in place."

On 2/1/22 at 1:40PM V8, Wound physician stated "A resident who is wound healing should be assessed by the dietitian and my recommendation would be Zinc, Multiple Vitamin, and (liquid protein supplement). My understanding is the facility starts that immediately when a wound is identified. I think definitely if a resident has a wound they would do at minimum weekly skin assessments. There needs to be a process in place where the CNA's and floor nurse's notify the wound nurse and the

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wound nurse notifies me. If there is not skin breakdowns could be missed. It all comes down to communication. It should be supervised by the Director of Nursing."

"B"

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300.610a)
300.1210b)
300.1210d)3)5)
300.1220b)2)

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

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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
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 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:
2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status,

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sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation

These Requirements were Not met evidended by:

Based on interview, and record review, the facility failed to assess or treat new skin issues for two residents (R5 and R9) of three residents reviewed for skin alteration in a sample list of 60 residents. This failure caused (R9) to develop full thickness wounds to the toe and heel and (R5) to experience worsening bruised swollen lower leg wounds.

Findings Include:

1. R9's progress notes printed 1/25/22 includes the following diagnoses: Type II Diabetes. Morbid Obesity, Peripheral Vascular Disease, and Muscle Weakness.

R9's progress note dated 11/15/21 at 1:36PM stated "Family notified of all skin issues, calloused area has fallen off tip of left great toe already, also noted a black 2nd toe on this foot, staff state this is not new, it has been there for a long time, but x-ray will be done to rule out injury."

There is no other documentation to address the wound on the second toe until R9's progress note of 11/23/21 which documents : "Wound found on left foot 2nd toe (between 2nd and 3rd digit, but on lateral part of 2nd toe) noted 4x4 gauze laying over wound, with dried bloody drainage. Cleansed, Unable to measure due to pain and resident not allowing. Pat dry. Applied calcium

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alginate and dry dressing-band-aid, until seen by wound doctor.
Notified family of all orders, and treatment also notified wound facility nurse, family states this was noted on Sunday by Family concerned due to resident being a diabetic."

R9's physician's wound documentation dated 11/26/21 documents a full thickness wound to R9,s Left Distal second toe with a surface area of 2.8 centimeters. The etiology is documented as infection. The wound physician's notes on 12/8/21 document minimal change to R9's left second toe. However, there is an additional newly acquired "full thickness arterial wound to left heel" with surface area documented as nine centimeters.

On 1/17/22 R9 was seen by V10, wound doctor. V10 recommended referral to a vascular surgeon. R9's progress note by V5, wound nurse dated 1/18/22 at 1:12PM documents "(R9) seen by wound doctor (V10) on wound rounds 1/16/22. Resident (family) at bedside and talked with (V10) regarding resident skin issues to left foot. (family) voiced understanding and will talk (other family) regarding resident seeing the vascular surgeon and get back with (facility).
R9's progress notes document R9 was not assessed by the facility dietitian until 1/18/22. Dietitian recommended a liquid protein supplement at that time. As of 1/25/22 there is no follow up documented to support the facility has followed up with family related to vascular consult.

On 2/1/22 at 1:40PM V8, wound doctor stated "It is my understanding (R9's) family does not want a vascular consult for (R9). (R9) has dry gangrene in that left foot. I would expect at minimum skin

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checks every week for high risk residents as well as dietitian consultation. (R9) is diabetic so that puts her at risk in itself. Good foot care is very important in a diabetic resident."

2. R5's Progress notes printed 1/25/22 include the following diagnoses: Mild Malnutrition, History of falling, Weakness, and heart Failure.

R5's Progress note dated 1/7/22 at 5:29AM documents " Writer was called into the room as (R5) was having bleeding from skin tears on her right leg. Noted R5 has two skin tear about the size of 2x5(centimeters) and other one about the size of 1x1(centimeters) below the knee. Cleansed with Normal Saline, applied steri-strips. Resident unable to tell how it happened. Denies any pain. Will continue to monitor. There is no documentation of skin assessments until a progress note dated 1/19/22 at 5:19PM which documents "This writer was called into R5's room due to her leg weeping, cleansed and put treatment in place, (Physician) and Power of Attorney notified. No skin assessment was documented.

On 1/24/22 at 10:10AM V31, R5's family member stated "we removed (R5) last week (from the facility) Her legs looked awful. They were edematous, leaking fluid. We had (telehealth) appointment with (V16, Physician) who had (family member) remove the bandages and (R5's) legs were bruised with open wounds, (V16) said it looked like it was from trauma, not being careful moving her. It was the calf area on the right leg."

On 1/25/22 at 2:13PM V16 stated "I have been (R5's) primary care physician for quite some time. I did a telehealth visit with (R5) with (family

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| S9999 | Continued From page 24<br>members) present in (R5's new facility). I instructed family to remove bandages from (R5's) right lower leg. I found what I saw disturbing. (R5) had two triangular shaped lacerations on her right lower leg surrounded by ecchymosis. I also noted the right leg had more edema than the left leg. I would not attribute this to (R5's) Congestive Heart Failure. These areas appeared to be traumatic as one would see in rough treatment of this 95 year old patient.<br><br>On 1/25/22 V2 Director of Nursing stated "(R5) was transferred to (new facility) by our van on 1/21/22. I am not aware (R5) had any wounds."<br><br>The facility's policy Wound Treatment Management dated 12/1/20 states "To promote healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician's orders. 1. Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. This policy also states "The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards wound healing b. Changes in characteristics of the wound and c. Changes in the resident's goals and preferences, such as end of life or in accordance with his/her rights." | S9999 | | |

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|---|---|---|---|
| | IL6005938 | A. BUILDING: ______<br>B. WING ______ | C<br>02/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOFT REHAB OF DECATUR | 500 WEST MCKINLEY AVENUE<br>DECATUR, IL 62526 |

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| S9999 | Continued From page 25 | S9999 | | |

"B"

( 3of 3)

300.610a)
300.1210b)
300.1220b)2)
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.

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

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| S9999 | Continued From page 26 | S9999 | | |

resident to meet the total nursing and personal care needs of the resident.

Section 300.1220 Supervision of Nursing Services

b)The DON shall supervise and oversee the nursing services of the facility, including:
2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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 evidended by:

Based on interview and record review the facility failed to ensure one resident (R17) was not subjected to mental or physical abuse by a staff member. R17 is one of seven residents reviewed for abuse in a sample list of 60 residents. This failure caused (R17) to suffer psychosocial harm manifested by tearfulness, fear, embarrassment, and voluntarily discharging from the facility to home and forfeiting remaining eligibility for therapy services, to avoid possible further occurrences of mistreatment.

Findings include:

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| S9999 | Continued From page 27 | S9999 | | |

R17's admission diagnoses sheet dated 1/18/22 includes the following diagnoses: Anemia, Weakness, Gastrointestinal Hemorrhage, Morbid Obesity, Depression and Anxiety Disorder.

R17's progress note dated 1/18/22 at 5:10PM documents "Able to self propel in wheelchair. Able to verbalize needs. Alert and Oriented X (times) 4 (Person,Place,Time,and situation)." This note also documents "(R17) baseline generalized weakness. However, is able to sit on side of bed per self. Transfers with 1 and gait belt. Steady gait with walker. (R17) uses a Bedside Commode and is continent x 2 (Bowel and bladder)."

On 2/1/22 at 2:40PM R17 stated " On 1/22/22 night shift, I put on my call light. First an aide came in and said she needed to go get help. The aide got (V22), LPN (Licensed Practical Nurse) to help. I told them I needed to move my bowels. I had my feet off the side of the bed, but I am weak in my upper body and need help to sit up. (V22) grabbed my leg hard, spun me around back in the bed and told me in a very rude way to 'just poop in my pants and they'd clean it up.' (V22) refused to give me the name of the aide. I started crying and I was afraid. They left me and finally I just had to go in my pants. I was embarrassed. I stayed dirty until my husband and the nurse who came in on day shift cleaned me up. I wanted to stay long enough to get some more therapy and get stronger, but I had my husband take me home that day. I just couldn't take it any longer." During the interview R17 was crying. R17 stated "I don't even like to remember it. I get nervous." (V24), R17's family member stated "(R17) had dried bowel movement on her. They just let her sit in filth all night."

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| S9999 | Continued From page 28 | S9999 | | |

On 1/31/22 at 12:30PM V21, Licensed Practical Nurse (LPN) stated "When I came in the morning of 1/22/22 (R17) and (V24) were very upset and wanted to take (R17) home. When I got in the room to check on (R17) (R17) was shaking and crying. I asked if I could help and (R17) said (V22) and a CNA who refused to give her name came in during the night when she rang her call light. (R17) can scoot herself to the edge of the bed but she is weak in the upper body so she needs help sitting up. (R17) said (V22) told her to get back in bed. She told (V22) she needed to go to the bathroom to have a bowel movement. (V22) yelled at her and said just go in your pants and we will clean it up later. (R17) is mostly continent and just wears an adult diaper for dribbling like when she coughs. Then (V22) grabbed (R17) hard by the leg and put (R17) in the bed. (R17) said it scared her. I wrote this all up and gave it to (V3), LPN (Licensed Practical Nurse) on 1/22/22. I have been a nurse since 1996. I would say this was abuse. I honestly couldn't find out who the CNA was. (R17) was alert and oriented and able to let us know what she needed or wanted."

On 2/1/22 at 11:00AM V25,CNA Certified Nurse's Aide stated "I was the CNA with (V22) who took care of (R17) the night before she left. I saw (V22) put (R17) back in the bed. This was the first time I ever had (R17) and I didn't know she could be up. I don't know if (V22) knew her either. It was the third time (R17) had put on her call light and I wasn't sure if I could get her up by myself or not. I didn't hear or see anything else."

On 2/1/22 at 11:15AM V22 was interviewed by telephone . V22 stated in a loud voice "I know you want to talk about a resident that left the facility. I already had to come in and write a

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| S9999 | Continued From page 29<br><br>statement. We went in and (R17) was hanging her legs off the bed. Her knees were against the wheelchair. I though she might fall. There was nothing unusual that night. I heard through the grapevine you already think I'm guilty."<br><br>The facility's Abuse, Neglect and Exploitation policy dated 6/8/20 states "5. Prevention of abuse neglect, and exploitation-The facility will consider utilization of the following tips for prevention of abuse, neglect, and exploitation of residents: j. Supervise staff to identify inappropriate behaviors such as using derogatory language, rough handling, or ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their beds."<br><br>" B" | S9999 | | |

LTC07202

# COMPLAINT DETERMINATION FORM

FAC. NAME: LOFT REHAB OF DECATUR  COMPLAINT #: 0142703
LIC. ID #: 0057000
DATE COMPLAINT RECEIVED: 01/19/22 15:23:00

| IDPH Code | Allegation Summary | Determination |
|---|---|---|
| 105 | IMPROPER NURSING CARE | 1 |
| 106 | COMMUNICABLE DISEASE | 1 |
| 402 | LACK OF STAFF | 2 |
| 409 | POLICY AND PROCEDURES | 2 |

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.