STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000186	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR NURSING & REHAB CENTER	4900 NORTH BERNARD CHICAGO, IL 60625

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S 000	Initial Comments Complaint Investigation 2284501/IL147793	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)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 300.1010 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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:	S9999		

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S9999	Continued From page 2 Based on observation, interview and record review, the facility failed to follow their policy to prevent and monitor a resident that acquired in the facility an initially assessed stage III pressure ulcer and failed to document in treatment administration record that, physician order treatment for the resident was being performed for 1 (R2) out of 3 residents reviewed for pressure ulcer and colostomy care. This failure resulted in R1 acquiring a facility acquired stage III pressure ulcer upon discovery. Findings Include: On 06/28/2022 at 10:58 AM, surveyor observed R2's sacral wound. Wound dressing was not dated. Wound had a large area with 3 parts, raw and has slough on the upper part of the wound with moderate amount of serosanguinous drainage. On 06/28/2022 at 11:00 AM, V3 (Registered Nurse) stated that to prevent worsening of a wound, the nurses are expected to turn and reposition the residents, use barrier cream, empty R2's ostomy bag frequently because his stool is liquid so it can leak, give him supplemental nutrition and encourage him to eat lunch to gain wait. When she found the wound on R2, she submitted an incident report for the wound nurse to check on R2. When R2 was admitted, he had a slight redness discoloration on his coccyx area. V3 stated she submitted the incident for the wound nurse on 6/1/2022. On 06/28/2022 at 11:27 AM, V4 (Wound Doctor) stated that on 06/07/2022 R2's wound had a measurement of 8cm width, 10 cm length. The sacral wound was staged as unstageable. V4	S9999		

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S9999	Continued From page 3 stated R2 refused treatment. "I was going to do a physical debridement but R2 refused". V4 stated, "On 06/14/2022, we started a chemical debridement. There was barely any improvement from that. On 06/14/2022 R2's sacral wound was staged as Stage III. There was no improvement of the wound." On 06/28/2022 at 12:34 PM, V8 (Wound Nurse/Licensed Practical Nurse) stated that R2's wound was discovered on 6/2/2022. V8 stated that the wound was staged at a Stage III. Currently the wound has not improved and stayed the same from discovery. The dressing is ordered to be changed daily. V8 stated that Santyl is the treatment medication used on the wound for R2. V3 stated that during initial assessment upon admission, R2 had a discoloration that had opened up later. V8 stated that R2's Stage III pressure ulcer was acquired in the facility. There is an order for treatment of R2's Stage III pressure ulcer to be implemented daily. The expectation for nurses at the facility is to follow physician orders. V8 stated that she usually is the one who completes the treatment for R2's pressure ulcer. V8 also stated that whoever does the treatment should document in the resident's medical record that the treatment was implemented and completed. If the resident's treatment administration record is not documented, that means the treatment was not done. Director of Nursing and Associate Director of Nursing are doing the inventory of appropriate treatments progress. Collagenase is the generic name for Santyl. V8 stated that she worked 6/21/2022 and 6/25/2022 and is not sure why R2's treatment administration record is not signed. On 06/28/2022 at 1:00 PM, V6 (Director of	S9999		

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S9999	Continued From page 4 Nursing) stated she won't be able to verify that treatment was done. She stated that the nurse should know that when the wound nurse is not available, they are expected to do the wound treatments. V6 stated that she assigned nurses for the weekend when the wound care nurse is not around, so they should do the treatments. She stated that when treatment administration record is not signed, that means the nurses did not do the treatment. V6 also stated, "As a nurse, Stage III pressure ulcer does not happen overnight." V6 stated she doesn't know why the wound was discovered as a stage III. Lastly V6 stated that R2's sacral wound was a facility acquired Stage III when discovered. R2's Facesheet documents in part: Admission date - 5/5/2022. R2's weekly skin check (6/2/2022) documents in part: Resident does have loss of skin integrity. Resident has a new loss of skin integrity. R2's Weekly Wound Evaluation (6/2/2022) documents in part: Stage III is when there is full thickness tissue loss. Subcutaneous fat may be visible. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling. Site: Coccyx, Type: Pressure injury: In-house acquired, Pressure ulcer stage: Stage III. Length: 10.0 cm, Width: 9.0 cm, Depth: 0.1 cm. Serosanguineous drainage. 50% Slough, Surrounding tissue: Erythema. R2's Weekly Wound Evaluation (6/8/2022) documents in part: Site: Coccyx, Type: Pressure injury: In-house acquired, Pressure ulcer stage: Unstageable. Length: 10.0 cm, Width: 9.0 cm. Serosanguineous drainage. 50% Slough, 30% Necrotic. Surrounding tissue: Erythema.	S9999		

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S9999	Continued From page 5 R2's Weekly Wound Evaluation (6/14/2022) documents in part: Site: Coccyx, Type: Pressure injury: In-house acquired, Pressure ulcer stage: Unstageable. Length: 10.0 cm, Width: 9.0 cm. Serosanguineous drainage. Surrounding tissue: Erythema. R2's Care Plan (6/23/2022) documents in part: The resident has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues. Sacrum. Scrotum, Right heel, left heel. left calf, left ischium. Precautions for prevention of Pressure Ulcers will be completed: good peri care and drying of the skin, Apply protective barrier cream, Reposition resident frequently. When in bed/chair/geri chair and/or W/C, Off load heels PRN, CNA shower and skin observations to be reported to nurse for any unusual findings or changes in the resident's skin integrity. Administer Wound Care (Treatments) per MD orders (See POS/TAR for current orders). Weekly measurements and documentation. R2's Active Orders on Physician Order Sheet documents in part: Collagenases Ointment 250 Unit/GM. Clean with Normal Saline, apply Santyl (Collagenases) to sacrum, scrotum topically everyday shift for wound care related to pressure ulcer of right buttock and cover with dry dressing. R2's Treatment Administration Record for June 2022 documents in part: Collagenase Ointment 250 UNIT/GM, apply to coccyx topically everyday shift for wound care related to pressure ulcer of right buttocks. Clean with NSS, apply Santyl (Collagenase) and cover with dry dressing -Start Date- 06/02/2022. No signed documentation for Sunday June 5th, 2022.	S9999		

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S9999	Continued From page 6 R2's Treatment Administration Record for June 2022 documents in part: Collagenase Ointment 250 UNIT/GM, apply to coccyx topically everyday shift for wound care related to pressure ulcer of right buttocks. Clean with NSS apply Santyl (Collagenase) and cover with dry dressing -Start Date- 06/07/2022. No signed documentation of treatment administration of sacrum on Sunday June 12th, 2022, Monday June 13th, 2022, Sunday June 19th, 2022, Monday June 20th, 2022, Sunday June 26th, 2022, and Monday June 27th, 2022. R2's Wound Evaluation and Management Summary signed by V4 (Wound Doctor) on 6/7/2022 documents in part: Unstageable (Due to Necrosis) Sacrum full thickness. Etiology: Pressure. Wound size (L x W x D): 8 cm x 10cm x Not measurable cm. Treatment: Santyl with gauze dressing complete once daily. R2's Wound Evaluation and Management Summary signed by V4 (wound Doctor) on 6/14/2022 documents in part: Stage 3 Pressure Wound Sacrum Full Thickness. Etiology: Pressure. Wound size (L x W x D): 8 cm x 10cm x Not measurable cm. Treatment: Santyl with gauze dressing complete once daily. Facility's Pressure Injury Prevention Policy (05/2017) documents in part: It is the policy of this facility to implement measures to protect the resident's skin integrity and prevent skin breakdown whenever possible. The purpose of this policy is to establish and provide consistent measures for the prevention of pressure injuries based upon the assessment of pressure injury risk. This facility will implement interventions based upon the results of the risk assessment.	S9999		

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S9999	Continued From page 7 Facility's Preventative Skin Care policy documents in part: It is the intent of the facility that the facility provide preventative skin care through careful washing, rinsing, and drying to keep residents clean, comfortable, well groomed and free from pressure sores. (B)	S9999		