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	IL6007181	A. BUILDING: _____ B. WING _____	C 11/02/2022

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S 000	Initial Comments Annual Licensure and Certification Complaint Investigation: 2248688/IL152812	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)3) 300.1210d)2)5)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All	S9999		

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S9999	Continued From page 2 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide timely and complete incontinence and catheter care for 5 of 5 residents (R5, R8, R16, R26, R206) reviewed for incontinent care in the sample of 37. The Facility also failed to provide care to promote healing and the prevent deterioration of Moisture Associated Dermatitis for 2 of 16 residents (R5, R26) reviewed for quality of care in the sample of 37 These failures resulted in R206 feeling demeaned and experiencing pain during incontinent care and the worsening of R26's Moisture Dermatitis . Findings include: 1. R206's Care Plan, dated 10/19/2022, documents, "The resident has an ADL (activities of daily living) self-care performance deficit" It continues, "TOILET USE: The resident requires (1) assist with toileting. Resident is incontinent of B&B (bowel & bladder) and wears briefs" It also documents, "I am at risk for a skin impairment r/t (related to) incontinence" It continues, "Keep skin clean and dry. Use lotion on dry skin." R206's Minimum Data Set (MDS), dated 10/20/2022, documents that R206 is cognitively intact. It also documents that R206 is occasionally incontinent and of urine, frequently incontinent of bowel and requires extensive assistance of 1 staff with toileting. On 10/25/2022 at 10:10 AM, V14, Physical	S9999		

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S9999	Continued From page 3 Therapist, notified V9, Assistant Director of Nursing (ADON), and V10, Certified Nursing Assistant (CNA), of R206 have soiled pants and requiring assistance. On 10/25/20022 at 11:30 AM, R206 stated that he would like to get cleaned up. R206 stated that he does not like sitting in his own feces. R206 stated that he doesn't like it and it's demeaning. R206 stated that he is a man, and this is not right. R206 then lowered his head and would not make eye contact. On 10/25/2022 at 12:24 PM, V14 stated that when she entered R206's room at 12:15 PM she noticed that R206 was sitting in the same position she left him and R206 had not been changed. V14 stated that she notified the ADON. Based on 15-minute observation intervals, R206 remained sitting in the wheelchair in the same soiled pants without benefit of incontinent care on 10/25/2022 from 10:10 AM to 1:00 PM. On 10/25/2022 at 1:00 PM V10, CNA, and V11, CNA, assisted R206 with incontinent care. V10 and V11 assisted R206 into a standing position. R206 pants were soiled with bowel. V10 and V11 assisted R206 into the bathroom and pulled R206 pants down. V11 attempted to remove R206's incontinent brief. The incontinent brief was stuck to R206's buttocks. V11 pulled the incontinent brief off and R206 yelled "Ouch." V10 then, using a washcloth and soap, cleansed the dried bowel from R206's buttocks. R206 observed with facial grimacing and asked, "What are you doing back there?" V10 continued to cleanse the buttocks and anal area. V10 and V11 then applied an undergarment and pants and assisted R206 into his wheelchair. V10 did not cleanse R206's penis	S9999		

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S9999	Continued From page 4 and scrotum. On 10/25/2022 at 1:20 PM, when asked if he have any pain when cleaned by the CNAs, R206 stated, "Yeah. It didn't feel good." On 10/26/2022 at 3:02 PM, V11, Corporate RN (Registered Nurse), stated that she would expect the staff to clean all areas of incontinence including the penis and scrotum. V11 stated that she expects the staff to perform catheter care when performing incontinent care. V11 stated that she expects staff to perform care in a timely manner. V11 stated that sitting in feces for waiting for 3 hours is not timely. On 10/26/2022 at 3:30 PM, V9, Assistant Director of Nursing (ADON), stated that she did not hear therapy say that R206 was dirty. V9 stated that there is no excuse. 2. R8's Care Plan, dated 10/18/2022, documents that "(R8) has an indwelling Catheter r/t neurogenic bladder and self-catheterization in the community. (R8) was retaining urine in the hospital and a Foley was placed. He failed voiding trials. Refuses Secure device for foley" It continues "Catheter care every shift and PRN (as needed)" R8's MDS, dated 9/9/2022, documents that R8 is cognitively intact, frequently incontinent of bowel and requires extensive assist for toileting. R8's Physician Order Sheet (POS), dated 10/25/2022 documents Urinary Tract Infection as diagnosis. On 10/25/2022 at 10:07 AM, observed V9, ADON, and V10, CNA, perform incontinent care.	S9999		

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S9999	Continued From page 5 R8 was incontinent of bowel. V9 and V10 pulled down R8's pants to his ankles. V9 and V10 then turned R8 onto his right side and V10 cleansed R8's anus and left buttock. V9 and V10 then turned R8 onto his right side and V10 cleansed R8's left buttock. V9 and V10 then turned R8 onto her back and cleansed R8's left and right groin. V9 and V10 then applied R8's undergarment. V10 did not cleanse R8's scrotum, penis and did not perform catheter care. 3. On 10/27/2022 at 09:05 AM, V11, CNA, cleansed R16's abdominal fold with a wet washcloth with peri wash on it, flipped washcloth over cleansed from abdominal fold down into left groin area. Then she took another wet washcloth with peri wash on it and cleansed the right groin area. V11 did not cleanse R16's labia or perineal area nor did she rinse off the peri wash or dry R16's abdominal fold or bilateral groin areas. V11 doffed her gloves and donned another pair without benefit of hand hygiene and assisted V10, CNA, with rolling R16 onto her left side. V11 removed urine-soaked incontinent brief, with gloved hands, took a wet washcloth, cleansed her right hip and rectal area, with a wet washcloth that had peri wash on it. There was peri wash on R16's right hip and V11 did not rinse off or dry the right hip. R16's Care Plan, dated 08/04/2020 documented "Provide peri care after each incontinent episode" R16's MDS, dated 08/15/2022, documented R16's cognition was moderately impaired, that she requires extensive assist of 2 staff for toileting and that she was frequently incontinent of urine and occasionally incontinent of her bowels.	S9999		

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S9999	Continued From page 6	S9999		

The facility's policy, "Incontinence Care", dated 10/2022, documented, "a. Wash the labia first then groin areas."

4. R5's Order Summary Report, dated 10/26/22, documents R5 was admitted on 12/15/21 and has diagnoses of Dysphagia, Obstructive and Reflux Uropathy, Urinary Tract Infection and Acquired absence of left and right leg above the knee amputations.

R5's MDS, dated 7/24/22, documents that R5 is severely cognitively impaired and requires extensive assistance of 2 staff members for bed mobility, totally dependent on 2 staff members for transfers and extensive assistance of 1 staff member for toileting and personal hygiene. This MDS also documents R5 has an indwelling catheter and is always incontinent of stool.

R5's Care Plan, undated, documents, "Resident has an actual skin impairment of MASD (moisture associated skin dermatitis). Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Minimize pressure over boney prominences. Treatment as ordered."

R5's Order Summary Report, dated 10/26/22, documents, "Collagenase Powder. Apply to sacrum and right buttock every day shift Mon (Monday), Wed (Wednesday), Fri (Friday) for Skin. Cleanse area apply collagen powder and hydrocolloid (a dressing)."

On 10/26/22 at 3:16 PM, V19, Licensed Practical Nurse (LPN), stated, "I am going to put (R5's) treatment on his bottom." V19 entered R5's room's, uncovered R5 and rolled R5 onto his

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S9999	Continued From page 7 side. V19 unfastened R5's incontinent brief. R5's brief was soiled with a large amount of stool. V19 refastened the incontinent brief and stated, "He needs to be cleaned up. I will let my aide know." V19 left the room. On 10/26/22 from 3:16 PM until 4:35 PM R5 was continually observed. No staff entered R5's room to provide R5 with incontinent care leaving R5's skin exposed to the feces. On 10/26/22 at 4:35 PM, when asked if V19 had told him R5 was soiled and needed to be cleaned up, V18 stated, "(V19) did not tell me a thing. I didn't know." On 10/26/22 at 4:40 PM, V18 entered R5's room. V18 removed R5's incontinent brief. R5 had a suprapubic urinary catheter. R5's incontinent brief was soiled with a large amount of stool. R5's bedding, gown and bed pad was wet. V18 using a washcloth had to make multiple wipes with the cloths to remove the dried-on stool from R5's buttocks. R5 also had dried stool on his scrotum and V18 needed to use multiple wipes with a washcloth to remove it. R5's buttocks and scrotum were red. V18 completed care for R5. When asked why R5's bedding and gown were wet on the back, V18 stated, "(R5's) catheter leaks." R5's Specialty Physician Wound Evaluation, dated 10/27/22, documents Site 2 Non-pressure wound Sacrum Full Thickness. Etiology: Moisture Associated Skin Damage. Duration: greater than 15 days. Wound Size: 1.0 x 3 x 0.2 cm (centimeters). Wound Progress: Deteriorated. This evaluation also documents, Site 3 Non-pressure wound of the Right, Upper, Medial Buttock Full Thickness. Etiology: Moisture	S9999		

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S9999	Continued From page 8 Associated Skin Damage. Duration: greater than 15 days. Wound Size: 0.3 x 0.1 x 0.1 cm. with 10% slough. Wound Progress: Improved. Surgical excisional debridement was performed on Site 3. On 11/1/22 at 12:00 PM, V1, Administrator, stated that the facility did not have a Moisture Associated Dermatitis policy. 5. R26's Admission Record, dated 10/31/22, documents, that R26 was admitted on 1/12/2018 and has diagnoses of Urinary Tract Infection and Hemiplegia and Hemiparesis. R26's MDS, dated 8/22/22, documents that R26 is severely cognitively impaired, requires extensive assistance of one staff member for bed mobility, transfer, toileting and personal hygiene. This MDS also documents R26 is always incontinent of bowel and bladder. R26's Care Plan, dated 9/2/22, documents, "I am risk for a skin impairment r/t (related to) aging / disease process, decreased mobility. Intervention: Keep skin clean and dry. Use lotion on dry skin." R26's Care Plan, dated 10/20/22, documents, "(R26) has an actual skin impairment of MASD to right and left buttock. Intervention: Treatment as ordered. Wound doctor to assess and treat as needed." R26's Care Plan, undated, documents, "I have alteration in urinary elimination: Urinary incontinence r/t Impaired mobility, Lack of sensation. Intervention: Incontinence management program prn (as needed). Monitor	S9999		

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S9999	Continued From page 9 for incontinence and change as needed. R26's Specialty Physician Wound Notes, dated 10/20/22, documents Site 1 Non-Pressure wound of the right buttocks full thickness. Etiology: Moisture Associated Skin Damage. Duration: greater than 7 days. Wound Size: 1.0 x (by) 0.5 x 0.1 cm (centimeters) with odor. It also documents, "Additional Wound Detail PT (patient) has developed new buttock wounds due to moisture."." "Chemical Cauterization of hypergranulation tissue performed on Buttock wound with topical anesthetic to facilitate healing." This Note also documents Site 2 Non-Pressure wound of the left buttocks full thickness. Etiology: Moisture Associated Skin Damage. Duration: greater than 7 days. Wound Size: 4.5 x 2.5 x 0.1 cm. On 10/26/22 at 3:37 PM, V18, CNA, entered R26's room. R26 was sitting in his recliner wearing light gray sweatpants. V18 stated that he was not aware of R26 being wet and that he just was assigned to this hall. The front of R26's pants were visibly wet. V18 stood R26 up and transferred him to bed. R26's back of sweatpants were visibly wet from his waistband to the middle of his thigh. V18 removed R26's urine and feces soiled incontinent brief. R26's buttocks, scrotum and groin were fire engine red. R26's buttocks had dry sticky feces on it. R26 has 2 moisture associated wounds on the upper left and right sacrum the approximate size of a dime. The wound beds were red. V18 stated that R26's skin is usually not red and that the areas to his sacrum are not new. R26's Specialty Physician Wound Notes, dated 10/27/22, documents Site 1 Non-Pressure wound of the right buttocks full thickness. Etiology:	S9999		

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S9999	Continued From page 10 Moisture Associated Skin Damage. Duration: greater than 14 days. Wound Size: 1.5 x 1.5 x 0.1 cm. Wound Progress: Deteriorated. It also documents, "Additional Wound Detail Since the last visit he has developed another small ulcerative area in the region. This Note also documents Site 2 Non-Pressure wound of the left buttocks full thickness. Etiology: Moisture Associated Skin Damage. Duration: greater than 14 days. Wound Size: 0.5 x 0.7 x 0.1 cm with scab. Wound Progress: Improved. On 10/27/22 at 10:45 AM, V9, ADON / Wound Nurse, stated that R26 should not be saturated in urine at any time and that it is not good for his wound healing. V9 stated, "This really makes me mad to hear." On 11/1/22 at 2:00 PM, V12, Regional Nurse Consultant, stated, "Staff should be checking on residents every 2 hours more if needed for incontinence. All areas that were soiled should be cleansed." The facility policy, dated 10/2022, documents, "Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every 2 hours and provided perineal and genital care after each episode. 4. Soap one cloth at a time to wash genitalia using a clean part of the cloth for each swipe. A. Wash the labia first then groin areas. B. Rinse with remaining cloth using clean surfaces for all three surface areas (female). Do not place soiled soapy cloths back in clean water basin until procedure completed. May drape soiled cloths over the side of the wash basin, or place directly in soiled linen plastic bag. In the	S9999		

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S9999	Continued From page 11 male resident, wash penis first, turn the resident to the side, then wash perineal area. C. Clean/ rinse inner / upper thigh areas to remove urine moisture. 5. Observe for redness, irritation and discharge. 6. Gently pat area dry with a towel from anterior to posterior. 7. Assist resident to turn to side away from you. 8. Using the final rinse cloth, from front washing, wash and rinse the peri-anal area. Pat dry. 9. Change gloves and perform hand hygiene." (B)	S9999		