STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009435	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUCONDA CARE	176 THOMAS COURT WAUCONDA, IL 60084

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3)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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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	S9999		

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S9999	Continued From page 2 services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure pressure reducing interventions were in place for residents with pressure injuries for 2 of 8 residents (R106, R183) reviewed for pressure injuries in the sample of 28. This failure resulted in R106's coccyx excoriation progressing to an unstageable pressure injury and R183's Stage 3 coccyx pressure injury advancing to an unstageable pressure injury. The findings include: 1. On 07/24/23 at 10:34 AM, R106 was in her room, sitting up in her wheelchair on a flattened pillow. R106 said she has a dressing on the sore on her bottom. R106 said the wound doctor comes, but her wound is not getting better. R106 said the wound doctor did a procedure the last time and her bottom is very inflamed and burns. R106 did not have a pressure reducing cushion in her wheelchair or a pressure reducing air mattress on her bed. On 07/24/23 at 12:57 PM, R106 was sitting in her wheelchair in the dining room on a flattened pillow. R106's Most Recent Skin Assessment dated 7/21/23 shows "pressure ulcer coccyx, Stage: Unstageable, Length:3.5 cm Width: 3 cm, Appearance: moist, color: gray, Drainage amount: small, Exudate: Purulent. On 07/25/23 at 9:40 AM, V5 Wound Registered	S9999		

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S9999	Continued From page 3 Nurse said wound assessments are done weekly and include measuring the wounds, assesses the treatment orders to determine whether to continue or change them, and looking at the pressure reducing interventions in place. V5 said pressure reducing intervention used are turn/reposition every 2 hours, low air loss pressure reducing mattress, protein supplements, and wheelchair cushions or roho cushions. V5 stated "any resident comes in with a pressure wound should have an air mattress. They should have some sort of pressure reducing cushion on their wheelchair. R106 has an unstageable pressure to her coccyx, it started out as just excoriation. R106 should have an air mattress and a wheelchair cushion." On 07/26/23 at 11:15 AM, V13 Wound Doctor stated "R106 has an unstageable pressure wound to her coccyx. I just debrided it last week; it was the first time seeing her and it was at unstageable. R106 should have low air loss mattress, nutritional supplements, and a wheelchair cushion in place. I believe I ordered one. The low air loss mattress and wheelchair cushion helps wounds from deteriorating by reducing the pressure by redistributing the pressure off the wound." R106's Physician Orders do not contain orders for a pressure reducing wheelchair cushion or air mattress. R106's Care Plan shows R106 was re-admitted on 3/12/23 with excoriation on the buttocks and is at risk for impaired skin integrity with interventions: pressure reduction support surface in bed and pressure reduction sitting/wheelchair surface. The same Care Plan was updated 7/12/23 and shows "resident has actual open	S9999		

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S9999	Continued From page 4 area: unstageable coccyx due to worsened excoriation. " R106's Skin Assessment dated 3/12/23 shows "excoriation/blistering to both buttocks." R106's Skin Assessment dated 5/23/23 shows "Moisture Associated Skin Damage (MASD) Excoriation on bilateral buttocks and coccyx with increased skin redness." R106's Skin Assessments on 6/27/23 and 7/4/23 shows "worsening MASD excoriation." R106's Progress Note from V13 dated 6/28/23 shows "discussed care and course of treatment and obtained general consent to evaluate and treat. Patient not seen, up in chair." R106's Skin Assessment on 7/12/23 shows "pressure ulcer, site: coccyx, Stage: unstageable, Length 6 cm, Width 6 cm, Appearance: slough, Color: yellow." R106's Progress Note from V13 dated 7/19/23 shows "unstageable pressure injury sacrum, 3.5 cm Length x 3 cm width. 100% slough. Post Debridement Wound Bed 3.5 cm length x 2.5 cm width x 1/1 cm depth. Removed some slough today, able to better determine depth but still 100% slough left on wound bed. Treatment Order: Preventative Wound Recommendations: Low air loss mattress recommended." The facility's View Delivery Order Form dated 7/25/23 shows a low air loss mattress was ordered for R106 on 7/25/23. 2. On 07/24/23 at 9:41 AM, R183 was in bed (on	S9999		

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S9999	Continued From page 5	S9999		

a regular mattress) with V7 (R183's husband) at bedside. V7 stated R183 has a sore on her bottom that causes her pain, she cries like a baby. They have not been changing the dressing. They didn't change it on Friday, Saturday, or Sunday. I'm here from 8 AM to 8 PM and they say they will take care of it, but they don't. They change it when they remember.

On 07/24/23 at 9:41 AM, V8 Certified Nursing Assistant (CNA) lowered R183's saturated brief and R183's dressing to her right buttock was undated, saturated with yellow/tinged with pink drainage, and was rolled up (not on wound) in the brief. R183 had a large golf ball size wound with immeasurable depth on her coccyx. R183's brief was completely saturated with urine. R183 had an open excoriated area on her left buttock. R183 winced when moved during incontinence care.

V8 said she had checked R183's brief at 8 AM and she saw a dressing in the brief but did not change R183 at that time.

On 07/24/23 at 11:45 AM, R183 was up in the wheelchair at bedside with V7. V7 said R183 was crying like a little girl, she is in so much pain from her bottom. V7 said he was there when V8 came in and checked R183 earlier, but V7 only looked at R183's brief and didn't check the dressing at all.

On 07/25/23 at 9:27 AM, R183 was in bed on her back. There was no air mattress on the bed.

On 07/25/23 at 1:30 PM, R183 was up in the wheelchair at the bedside with V7. There was an air mattress on the bed. V7 stated "they just put that mattress on the bed now. I've been asking for a month for that bed! She had one like that in

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S9999	Continued From page 6 the hospital." R183's Physician Orders shows R183 was admitted on 6/20/23. R183's Skin Assessment dated 6/20/23 shows "sacrum: stage 3, length: 4.5 cm, width: 2.5 cm, depth: 0.5 cm, Appearance: dry, pink, no drainage or exudate." R183's Skin Assessment dated 7/18/23 shows "sacrum: unstageable, Appearance: necrotic, Color: gray, Drainage: moderate, Exudate: sanguineous." R183's Physician Progress Note by V13 dated 7/19/23 shows "Unstageable Coccyx pressure injury. Post Debridement Wound Measurement 3 cm length x 3 cm width x 0.8 cm depth with 50% slough remaining. Treatment Order: Every Day and as needed cleanse wound with normal saline, santyl nickel thick layer, cover with moist gauze." On 07/26/23 at 11:15 AM, V13 Wound Doctor stated "R183 has an unstageable on her coccyx. She should have an air mattress. It off loads to decrease the pressure on the wound to help heal. In general, all pressure wounds that are stage 2 or greater should have air mattress and wheelchair cushions to reduce pressure." On 07/25/23 at 9:40 AM, V5 Wound Registered Nurse said wound assessments are done weekly and include measuring the wounds, assesses the treatment orders to determine whether to continue or change them, and looking at the pressure reducing interventions in place. V5 said pressure reducing intervention used are turn/reposition every 2 hours, low air loss	S9999		

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S9999	Continued From page 7 pressure reducing mattress, protein supplements, wheelchair cushion or roho cushion. V5 stated "any resident comes in with a pressure wound should have an air mattress. They should have some sort of pressure reducing cushion on their wheelchair. I thought R183 had an air mattress, I'll have to double check. If a dressing is rolled or not in place it should be changed right away." R183's Care Plan dated 6/26/23 shows R183 has an alteration in skin integrity and lists "pressure reduction support surface in bed." R183's Physician Orders shows R183 was admitted on 6/20/23 and contains no order for a low air moss mattress. The facility's Prevention of Pressure Ulcers/Injuries Policy dated 9/2021 shows "review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Conduct a comprehensive skin assessment including areas of impaired circulation due to pressure from positioning. Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body weight, and overall risk factors. Review the interventions and strategies for effectiveness on an ongoing basis." (B)	S9999		