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S 000	Initial Comments Complaint Investigation 2492648/IL171548	S 000		
S9999	Final Observations Complaint Investigation 2492648/IL171548 Statement of Licensure Violations: 300.610a)2) 300.1210b) 300.1210d)2)5) 300.1220b)2)3) 300.3220f) 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. 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services,	S9999		

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S9999	Continued From page 1 dietary services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray); 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. Restorative measures shall include, at a minimum, the following procedures: 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.	S9999		

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S9999	Continued From page 2 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. 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 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing	S9999		

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or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to have a treatment order in place and failed to perform dressing changes to the sacral wound for seven days. This affected one of three residents (R1) reviewed for wound care in a total sample of six. This failure resulted in the sacral wound deteriorating by becoming larger in size, and R1 being diagnosed with osteomyelitis of the sacral wound after being hospitalized for an elevated white blood cell count indicating an infection.

Findings Include:

R1 is an 87 year old with the following diagnosis: adult failure to thrive, dementia, cerebral infarction, type 2 diabetes, stage 4 pressure ulcer of the sacral region, pressure induced deep tissue damage of the left and right heel, stage 3 pressure ulcer of the right upper back, and osteomyelitis of the sacral region.

The Admission Hospital Records dated 1/17/24 document R1 had a skin and wound consult for a DTI (deep tissue injury) to the right anterior ear that measured 3 cm x 1 cm, a DTI to the right clavicle that measures 0.5 cm x 1 cm, a DTI to the right chin that measured 0.5 cm x 1 cm, a DTI to the left heel that measured 3 cm x 4.7 cm, a DTI to the right heel that measured 3 cm x 5 cm, and a sacrococcyx stage 2 that was partial

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thickness skin loss that measured 4 cm x 0.5 cm x 0.1 cm.

The Admission Observation dated 1/17/24 documents R1 was admitted from the hospital with a pressure ulcer to the coccyx, right buttocks, abscess to the right ear, pressure injury to the right heel and left.

A Nursing note dated 1/17/24 documents R1 arrived to the facility from the hospital. Skin issues were noted on the coccyx, right buttocks, right and left heel, right clavicle, and right ear. The physician and the DON were made aware of the admission.

The Physician Order Sheet documents an order for an unstageable DTI to the sacrum was to be cleansed with wound cleanser, then apply alginate calcium, then cover with border once a day for wound care. This order was placed on 1/24/24. There is only an order for zinc barrier cream to be applied to the coccyx area once a day in the evening. The order for the zinc barrier cream was not started until 1/21/24.

The Treatment Administration Record (TAR) dated 01/2024 documents there is no dressing change order for the sacral wound until 1/25/24. The zinc barrier application once daily was started on 1/21/24.

A Lab Result note dated 2/10/24 documents a white blood cell count of 20.7 uL (4.5-11 uL), CRP of 126.2 mg/dL (normal is less than 0.3 mg/dL), and an ESR of 55 mm/hr (normal is 0-15 mm/hr). The physician was notified and ordered to send R1 to the hospital. The physician was unsure of the source of infection. R1 does have a sacral wound.

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S9999	Continued From page 5 The Hospital Records dated 2/11/24 document R1 presented to the hospital for abnormal labs. R1 was sent for an evaluation of an elevated white blood cell count of 21,000. R1 denied any symptoms. The chest x-ray was negative, the blood cultures had no growth, and the urinalysis was without a urinary tract infection. R1 was reporting pain in the back. R1 was noted with a stage 4 sacral ulcer with a foul odor. The increased white blood cells are likely secondary to the sacral wound/osteomyelitis. Wound care was consulted. An Infectious Disease note from the hospital dated 2/14/24 documents R1 had an infected sacral decubitus ulcer. Plan is to continue IV antibiotics monitor the white blood cell count. A General Surgery note from the hospital dated 2/14/24 documents the sacral ulcer is a stage 4 with undermining and extends to the bone. The sacral wound measures 5 cm x 3 cm. A General Surgery note from the hospital dated 2/19/24 documents R1 underwent a debridement of the sacral wound and a bone biopsy. R1 was noted to have a necrotic wound to the sacrum with that extended down to the bone. During the debridement, the physician was able to get down to the bone layer and the bone appeared to be infected with a necrotic coccyx that was loose as well as severely eroded. The area of debridement measured 11 cm x 10 cm. After being stabilized, R1 returned to the facility on 2/24/24. A Nursing note dated 2/24/24 documents R1 returned to the facility from the hospital. Wounds were observed on the right ear, right upper back, sacrum, and both heels. Infection Charting date 3/12/24 documents R1 is receiving three different kinds of IV antibiotics for a wound infection.	S9999		

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A Nursing note dated 3/14/24 documents the nurse practitioner ordered R1 be sent out to the hospital for evaluation. R1 had increased respiratory rate of 22 (normal is 12-16) and is now wearing 1 L of oxygen nasal cannula. The oxygen saturation are 96%. Blood pressure slightly low at 95/53.

The Death Certificate dated 3/20/24 documents the cause of death as pneumonia and osteomyelitis.

On 4/12/24 at 2:03PM, V3 (Wound Nurse/Floor Nurse) stated R1 admitted to the facility with an open wound to the right ear, deep tissue injury to bilateral heels, and a wound to the sacrum. V3 was not able to recall the stage of the sacral wound upon admission. V3 was also unable to recall why R1 went to the hospital on 2/10/24. V3 reported osteomyelitis is an infection that starts in the wound and enters into the bone. V3 denied being aware of R1 having any signs or symptoms of infection in the sacral wound. V3 stated signs of infection would be increased drainage, foul odor, or a change to the drainage. V3 reported the physician should be notified immediately of changes to the wound. V3 stated the best way to prevent infection in a wound is to perform the dressing changes to keep the wound clean.

On 4/12/24 at 3:09PM, V6 (Nurse) stated V6 admitted R1 to the facility and R1 had wounds to the ear, sacrum, and bilateral heels. V6 was not able to remember what the stage of the sacral wound was on admission but admitted the wound was an open wound. V6 reported that when a resident is admitted the physician must be called to see what orders are going to be continued form the hospital and if any new orders will be put in

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place. V6 was not able to recall what was ordered for the wound on the night of admission. V6 stated if an order was not put in place on the shift a resident was admitted then it should be put in place the next shift. V6 reported the importance of an order for dressing changes is to make sure the wound is being treated and assessed. V6 also admitted to being the nurse that sent R1 out to the hospital on 2/10/24. V6 stated R1 had an elevation of white blood cell count and the physician was concerned for an infection so R1 was sent to the hospital. V6 denied R1's sacral wound having any signs or symptoms of infection the day R1 went to the hospital. V6 reported signs and symptoms of infection are foul odor, increase in pain, and purulent drainage. V6 stated R1 was diagnosed at the hospital with a wound infection.

On 4/12/24 at 3:29PM, V7 (Nurse) stated V7 was aware R1 had an infection to the wound but V7 was unaware of what kind. V7 reported signs of infection are changes in vital signs, changes in drainage of the wound, and foul odor.

On 4/12/24 at 3:42PM, V2 (DON) stated R1 was admitted with bilateral heel DTIs and a sacral wound. V2 believed the sacral wound was a DTI as well because they were not able to see what was underneath the wound. V2 reported in 02/2024, R1 went out to the hospital for elevated white blood cell count and the facility was not able to identify a source of the infection. V2 denied R1 having any signs of symptoms of infection but stated the sacral wound ended up being the source of infection and was diagnosed with osteomyelitis. V2 reported once R1 returned from the hospital, R1's white blood cell count never returned to normal and remained elevated. V2 stated osteomyelitis is an infection of the bone that has migrate from another part of the body

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that had an infection.

On 4/15/24 at 11:07AM, V9 (Wound Physician) stated R1 was admitted to the facility with the same wounds R1 was discharged from the facility with. V9 was unable to name all the wounds. V9 reported R1 was sent to the hospital in 02/2024 for elevated white blood cell count, CRP (C-Reactive Protein, a lab test that checks for inflammation), and ESR (Erythrocute Sedimentation Rate, a lab test that checks for inflammation) along with a concern for osteomyelitis. V9 stated V9 was unable to remember the exact conversation but V2 reached out to V9 with concerns with the sacral wound so that prompted laboratory testing. V9 was unable to give a timeline on when a resident begins to show symptoms of osteomyelitis because "every resident is different." V9 stated R1 developed necrotic tissue to the sacral wound and due to the necrotic tissue, they were unable to see if there was any infection underneath the wound. V9 denied being aware of R1 having any signs or symptoms of infection to the sacral wound. V9 reported this time of infection develops in the wound first and then moves to the bone. V9 stated if no dressing order is in place from the hospital then staff should reach out to V9 or another physician for an order. V9 denied being aware that no dressing changes were in place for one week for R1. V9 reported if dressing changes aren't being done then the wound could develop an infection due to not being clean. V9 stated zinc barrier cream is not a treatment for a wound because it will assists in keeping moisture off the skin but will not clean a wound.

On 4/15/24 at 1:16PM, V2 stated the admitting nurse is responsible for getting orders from the physician once a resident is in the facility. V2

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reported any care that is provided to a resident needs to have an order put into the computer system and agreed that all wound care and dressing changes requires an order. V2 stated the nurse is responsible for observing any changes to the skin and reporting them to the physician. V2 reported if a resident discharges from the hospital without any orders for wound care then the wound needs to be discussed with the physician so an order can be put in the computer. V2 stated an order for a dressing change needs to be put into place no later than 24 hours after the wound was found. V2 reported there is no reason a wound should not have any dressing change orders in place for one week. V2 stated an order needs to be put into place as soon as possible so care can be provided. V2 reported if no order was put in place then there is no way to guarantee dressing changes were being performed. V2 stated an infection can develop if the dressing changes are not done. V2 reported R1 having no order for the sacral wound should have been brought to V2's or the physician's attention sooner than one week.

Per the National Pressure Injury Advisory Panel (https://npiap.com/general/custom.asp?page=PressureInjuryStages) the definition of a stage 2 pressure ulcer is, "partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and
may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper
tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence

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associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)." In conclusion, a stage 2 pressure ulcer is an open wound.

The Wound Assessment Details Report dated 1/19/24 documents a wound to the coccyx that is a stage two that measures 4 cm x 5 cm x 0.2 cm. There are no signs of infection documented.

The Wound Physician notes dated 1/23/24 documents R1 has an unstageable DTI to the sacrum that measures 8 cm x 5.1 cm x 0.1 cm. The wound is 70% granulation tissue and 30% skin. The plan is to apply calcium alginate once daily for 30 days.

The Wound Assessment Details Report dated 1/25/24 documents a wound to the coccyx that is a stage two that measures 4 cm x 5 cm x 0.2 cm. This wound is considered stable at this time. It is documented that treatment in place.

The Wound Assessment Details Report dated 1/30/24 documents a stage two to the coccyx that measures 8.3 cm x 6 cm x 0.1 cm. No signs of infection or documented. This wound is considered deteriorated due to an increase in size.

The Wound Physician note dated 1/30/24 documents an unstageable DTI to the sacrum measures 8.3 cm x 6 cm x 0.1 cm. The wound is now 50% necrotic tissue, 30% granulation tissue, and 20% skin. The wound progress is documented as exacerbated due to nutritional compromise.

The Wound Assessment Details Report dated

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S9999	Continued From page 11 2/6/24 documents a wound to the coccyx that measures 10.5 cm x 7 cm by unknown. This is now classified as a stage four and was debrided on this day. The wound is considered deteriorating due to an increase in size. There are no signs of infection documented. The Wound Physician note dated 2/6/24 documents the stage four pressure wound to the sacrum measures 10.5 cm x 7.3 cm x 0.1 cm. The wound is 70% necrotic tissue, 10% granulation tissue, and 20% skin. The wound was debrided on this day to remove necrotic tissue and establish the margins of viable tissue. The wound is considered exacerbated due to generalized decline of the patient. There are no signs and symptoms of infection documented at this time. The Wound Physician note dated 2/27/24 documents the stage four to the sacrum measures 11.4 cm 9.2 cm x 3.7 cm. The necrotic tissue is 20%, the granulation tissue is 25%, and viable tissue (bone) is 55%. This wound is considered exacerbated due to the osteomyelitis with debridement in the OR. The Braden Observation 1/24/24 documents score of 17 indicating at risk for developing pressure ulcers due to being occasionally moist, chairbound, having slightly limited mobility, and a potential problem with friction and shearing. The Infection Charting dated 2/27/24 documents R1 has an infection to the sacral wound and is receiving two different kinds of IV antibiotics. The Care Plan that is not dated documents R1 has a potential for impairment to skin integrity related to impaired mobility and incontinence. R1	S9999		

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has a pressure ulcer on the coccyx/buttocks upon admission and bilateral DTIs on the heels that were present upon admission. An intervention documented is to treat per physician order.

The policy titled, "Pressure Ulcer Prevention," dated 1/15/18 documents, "Purpose: To prevent and treat pressure sores/pressure injury. Guidelines: ...2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures." The policy titled, "Admission of Residents," that is not dated documents, " ...Procedure: ...8. Conduct head to toe nursing assessment of body systems, parts, and surfaces, identifying functional status, abilities, needs, or problems. This is to be used as baseline for the plan of care and obtaining comprehensive physician orders. 14. Moisture barrier may be applied by CNA as needed to intact skin and may be kept at the bedside." The policy titled, "Skin Condition Assessment and Monitoring - Pressure and Non-Pressure," dated 6/8/18 documents, "Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure, injuries, and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: ... Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment ...Caregivers are responsible for promptly notifying the charge nurse of skin breakdown ...Wound Assessment/Measurement: ...3 ... Dressings will be checked daily for placement, clean list, and signs and symptoms of infection."

(A)