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S 000	Initial Comments Complaint Investigation 2424774/IL174504	S 000		
S9999	Final Observations Statement Of Licensure Violations: 300.610a) 300.1210a)5) 300.3210a) 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

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resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 300.3210 General

a)No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act)

Section 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 regulations were not met as evidenced by:

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Based on observation, interview, and record review the facility failed to perform pressure ulcer risk assessments as directed by the facility's policy, failed to develop and implement pressure relieving interventions, failed to develop pressure ulcer care plans, and failed to assess a pressure ulcer weekly or obtain a treatment once a pressure ulcer was identified for three of three residents (R1, R2, and R3) reviewed for pressure ulcer development in the sample of four. These failures resulted in R1's left hip stage one pressure ulcer being left untreated and deteriorating from a stage one pressure ulcer to a stage four pressure ulcer that required surgical debridement and R2 developing an unstageable facility-acquired necrotic (dead tissue) pressure ulcer to the right heel.

Findings include:

The facility's Pressure Injury Prevention and Management policy dated 02/2023 documents, "The facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. "Pressure Ulcer Injury" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. "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 resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the

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interventions; or revise the interventions as appropriate. 2. The facility shall establish and utilize a systemic 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 a. Licensed nurses will conduct a pressure injury risk assessment using the designated tool, on all residents upon admission/re-admission, weekly times for weeks, then quarterly or whenever the resident's condition changes significantly. b. The tool will be used in conjunction with other risk factors not captured by the risk assessment tool. Example of risk factors include, but are not limited to:
Impaired/decreased mobility and decreased functional ability; co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; drugs such as steroids that may affect healing; impaired diffuse or localized blood flow; resident refusal of some aspects of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; under nutrition, malnutrition, and hydration deficits; the presence of a previously healed pressure injury. d. Assessments of pressure injuries will be performed by a licensed nurse and documented on the designated form. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS (Minimum Data Set). 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

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will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. c. Evidence-based interventions for preventions 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 redistribute pressure (such as repositioning, protecting, and offloading heels), provide appropriate pressure-redistributing, support surfaces, provide non-irritating surfaces, and maintain or improve nutrition and hydration status. d. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care. f. Interventions will be documented in the care plan and communicated to all relevant staff. g. Compliance with interventions will be documented in the weekly summary charting. 5. Monitoring b. The attending physician will be notified of the presence of a new pressure injury upon identification, the progression towards healing, or lack of healing, of any pressure injuries weekly, and any complications as needed. 6. Modification of interventions a. Any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner. b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include changes in resident's degree of risk for developing a pressure injury, new onset or recurrent pressure injury development, lack of progression towards healing, resident non-compliance, and changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights."

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1. R1's MDS (Minimum Data Set) Assessment dated 3-12-24 documents R1 was a 69-year-old with severely impaired cognition that required moderate assistance for rolling left and right and was completely dependent on staff for transfers. This same MDS documents R1 did not have any pressure ulcers on admission and was not on a turning and re-positioning program.

R1's Progress Notes document R1 passed away on 3-26-24.

R1's Medical Record dated 3-8-24 (admission to the facility) through 3-26-24 (date of R1's death) does not include an assessment of R1's pressure ulcer risk.

R1's Progress Notes dated 3-20-24 and signed by V6 (RN/Registered Nurse) documents, "Assessed (R1's) left hip for wound. (R1) admitted to facility with a stage one pressure injury to left hip. Stage three wound noted to left hip measures 1.5 cm (centimeters) length by 1.8 cm width by 2.0 cm depth. Undermining around inside wound bed full diameter of wound 2.1 cm. (R1) noted to have moderate amount of yellow purulent drainage on dressing.
At twelve o'clock there is a stage two pressure injury 3.0 cm length by 3.0 cm width by 0.1 cm depth. Erythema around wounds 5.6 cm and blanchable. New order to pack wound with lodoform gauze strip and cover with six-by-six optifoam dressing daily and PRN (as needed)."

R1's Medical Record dated 3-8-24 through 3-26-24 does not include documentation, weekly assessments, or a treatment of R1's pressure wound of the left hip pressure ulcer prior to 3-20-24.

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R1's Care Plan dated 3-8-24 through 3-26-24 does not include a plan of care to address R1's pressure ulcer to the left hip, or a plan of care with pressure relieving interventions or goals.

R1's Initial Wound Evaluation and Management Summary dated 3-21-24 and signed by V9 (Wound Physician) documents, "Chief complaint: (R1) present with a wound on his left hip. Stage four pressure wound of the left hip full thickness. Etiology: Pressure. MDS stage four. Duration: Over 21 days. Wound size 1.5 cm length by 1.2 cm width by 1.1 cm depth. Slough (dead inflammatory tissue) 20 percent. Other visible tissue: 80 percent (hardware, tendon, muscle, and subcutaneous tissue). Dressing Treatment Plan: Alginate calcium with silver once daily and cover with foam with border once daily. Off-load wound. Reposition per facility protocol. Turn side to side in bed every one to two hours if able."

On 6-27-24 at 1:35 PM V18 (Assistant Director of Nursing) stated, "(V19/Prior MDS Coordinator) was responsible for the Braden Scale Pressure Risk Assessments (Pressure Risk Assessment) and Care Plans during the time (R1) resided within the facility. (R1) did not have any Braden Scales Pressure Risk Assessment completed at all when (R1) resided here, did not have a pressure ulcer prevention care plan developed with pressure relieving interventions prior to (R1s) pressure ulcer development, and did not have pressure ulcer care plan development once (R1) developed a pressure ulcer. (R1's) wound to the left hip was caused by pressure. I did not know (R1) had a stage one pressure ulcer to his left hip when he was admitted here. I only knew about (R1's) pressure ulcer to the left hip when (V6/RN) found it was opened up (on 3-21-24). I know

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(R1) preferred to lay on his left hip and the staff had a hard time getting him to turn off of his left hip. We (the facility) did not address or develop a plan of care/interventions to address (R1's) refusal to turn off of the left hip, or to provide pressure relief to (R1's) left hip."

On 6-27-24 at 1:55 PM V6 (RN) stated, "When (R1) was admitted to the facility (3-8-24) with a stage one pressure ulcer to the left hip that measured around three centimeters by two centimeters and was red in color, we (the facility staff) did not get a treatment order or measure the area weekly. We just tried to keep (R1) off of his left hip as much as possible. I found the left hip wound on 3-21-24 and it had opened up and was worse. I referred (R1) to the wound physician for assessment and treatment."

2. R2's MDS Assessment dated 4-26-24 documents R2 is a 98-year-old with severely impaired cognition that is completely dependent on staff for rolling left and right and transfers. This same MDS documents R2 is at risk of development of pressure ulcers and is not on a turning and re-positioning program.

R2's Braden Scale for Predicting Pressure Ulcer Risk Assessment dated 12-6-23 documents R2 was at risk for pressure ulcer development.

R2's Braden Scale for Predicting Pressure Ulcer Risk Assessment dated 6-21-24 documents R2 is at moderate risk for pressure ulcer development.

R2's Progress Notes dated 6-17-24 document R2 had a significant weight loss within the last month of six percent.

R2's Progress Notes dated 6-20-24 document R2

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started to experience a change in condition and started to become more lethargic, have a dry cough, had some green phlegm, was experiencing confusion, and was having a decreased appetite.

R2's Progress Notes dated 6-21-24 at 3:29 PM and signed by V2 (Director of Nursing) document, "Skin Issue. Deep tissue injury. Right heel length 3.0 cm (centimeters) by 2.0 depth. Brown cover."

R2's Medical Record does not include a completion of a quarterly Braden Scale for Predicting Pressure Ulcer Risk Assessment between 12-6-23 through 6-21-24, or before the development of R2's pressure ulcer development to the right heel on 6-21-24.

R2's Emergency Department Notes dated 6-21-24 at 5:21 PM document, "(R2) presents to emergency room via EMS (Emergency Medical Services) for complaints of lethargy by house staff. Per EMS, (R2) has been weaker than normal and family recently visited (R2), noticing this change on condition, (R2) does have a right lower extremity treatment in place which has a pressure ulcer."

R2's Emergency Department Notes dated 6-22-24 at 1:46 AM document, "(V10/R2's Family Member) reports that (R2) resides at skilled nursing facility where she frequently visits her and states that since Monday (R2) has been far more lethargic that normal. Skilled nurse (at) facility reports that (R2) has not been eating all of her meals, and states (R2) has been sleeping more than usual. (V10) reports (R2) has a wound on her right heel that she is concerns is making (R2) septic. Skin: Right heel ulcer with overlying eschar (dead tissue) present."

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R2's Hospital Wound/Ostomy notes dated 6-24-24 document, "Wound history: Right heel pressure injury-unstageable pressure injury. Measurements: 4.0 cm by 4.0 cm with no measurable depth-full thickness. Notes: Continue with air mattress, disposable pads, and heel boots."

R2's Care Plan dated 8-2-22 (Admission) documents, "(R2) is at risk for alteration in skin integrity related to Diabetes, Peripheral Vascular Disease, impaired mobility, and normal disease progression. Goal: Encourage to re-position as needed. Use pillows/positioning devices as needed."

R2's Care Plan dated 6-21-24 documents, "(R2) has an alteration in skin integrity-Right heel has a brown scab area. Goal: To heal thru next review date. Interventions: Heel protector to right heel."

R2's Initial Wound Evaluation and Management Summary dated 6-26-24 and signed by V9 (Wound Physician) documents, "Chief complaint: Present with a wound on her right heel and a rash. Focused Wound Exam: Unstageable due to necrosis of the right heel full thickness. Etiology: Pressure: Duration: Over six days. Wound Size 2.5 cm length by 2.4 cm width by 0.1 cm depth. Exudate: Moderate serosanguinous (bloody-clear drainage). 90 percent thick adherent black necrotic tissue. 10 percent thick adherent devitalized necrotic tissue. (R2) is still very deconditioned and high risk for further pressure injury. I do not think PAD (Peripheral Artery Disease) caused the wound (is not severe enough to cause tissue loss). Utilized the (pressure relieving boots) at all times. May be removed during transfers. Leptospermum honey

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apply three times per week, cover with abdominal pad, and gauze roll. Off-load wound. Re-position per facility protocol." This same Wound Evaluation documents V9 performed a surgical excisional debridement to R2's right heel wound to remove the necrotic tissue, eschar, and devitalized tissue."

On 6-26-24 at 11:45 AM R2 was sitting in a wheelchair in her room with slipper socks on both of her feet. R2 did not have pressure relieving boots on during this time. Both of R2's feet/heels were sitting directly on the floor and R2's pressure relieving boots were sitting on top of R2's bed. V6 performed a treatment to R2's right heel wound. R2's right heel wound was a round quarter-sized area that was beefy red in color and had a moderate amount of serosanguinous drainage. After V6 performed the treatment to R2's right heel wound, V6 did not apply pressure relieving boots to R2's feet. V6 then left the room, leaving R2 sitting in her wheelchair with her feet/heels sitting directly on the floor without pressure relieving boots.

On 6-26-24 from 1:15 PM through 2:30 PM R2 was sitting in a wheelchair in her room. R2 had slipper socks on both of her feet. R2 did not have pressure relieving boots on during this time. Both of R2's feet/heels were sitting directly on the floor and R2's pressure relieving boots were sitting on top of R2's bed.

On 6-26-24 at 11:30 AM V12 (CNA/Certified Nursing Assistant) stated, "(R2) was not feeling well for about three days prior to going to the hospital (on 6-21-24). (R2) was not eating well and not getting out of bed much. We (facility) staff would have to turn (R2) while she was in bed. We never put foot protector boots on (R2)

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and never lifted (R2's) feet off of the bed with pillows or anything."

On 6-26-24 at 2:05 PM V14 (CNA) stated, "(R2) started not to feel well before going to the hospital. I know the Thursday before (R2) went to the hospital (6-20-24), (R2) did not get out of bed at all. (R2) did not have heel protecting boots or offloading to her heels prior to hospitalization (6-21-24)."

On 6-26-24 at 2:10 PM V15 (CNA) stated, "(R2) has never had heel protecting boots and I have never lifted her heels off of the bed. I still don't think she has heel protectors."

On 6-27-24 at 10:30 AM V10 (R2's Family Member) stated, "I saw her on 6-19-24 (Wednesday) and saw a bandage on her right heel. I only saw a bandage. The staff told me there was a blister that had broken open and they put a bandage on it. On Friday (6-21-24) the right heel wound was blackish/brown and did not look good. (R2) had been deteriorating since last Wednesday (6-20-24). I had never saw heel protectors on her or her heels elevated off of the bed prior to (R2) getting the right heel wound. (R2) did not get out of bed at all last Thursday (6-20-24) or Friday (6-21-24)."

On 6-27-24 at 1:35 PM V18 (Assistant Director of Nursing) stated, "I did wound rounds with (V9) yesterday (6-26-24) but did not get time to process (R2's) orders to wear pressure relieving boots before I left yesterday. (R2) was supposed to have pressure relieving boots on at all times."

On 6-27-24 at 1:45 PM V2 (Director of Nursing) stated, "(R2) did not have a quarterly Braden Scale for Predicting Pressure Ulcers Risk

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Assessment done quarterly between 12-6-23 through 6-21-24, and one should have been completed around 3-6-24. I did (R2's) Braden Score on 6-21-24 and it was not coded correctly. (R2) was coded as a moderate risk and should have been coded as a high risk. I am not sure what we (facility staff) do once we determine a resident's Braden scale risks to be low, medium, or high. (R2) was not getting her heels off-loaded and did not have pressure relieving boots on prior to (R2) developing the pressure ulcer to the right heel. I found the pressure ulcer to (R2's) right heel on 6-21-24. When I found (R2's) area to the right heel it was covered with clear brown eschar and was unstageable. (R2's) right heel wound was caused by pressure."

3. R3's Braden Scale for Predicting Pressure Ulcer Risk Assessment dated 6-25-24 documents R3 was a high risk of development of pressure ulcers, was bedfast, was very limited in mobility, and has a problem with friction and shearing that requires moderate to maximum assistance when moving.

R3's current Care Plan does not include a plan of care with pressure relieving interventions to address R3 being at high risk for pressure ulcer development.

On 6-26-24 at 11:35 AM R3 was lying in bed with a pillow under her feet. Both of R3's heels were laying on top of the pillow.

On 6-26-24 at 11:40 AM V6 verified R3's heels were sitting directly on top of pillows. V6 stated, "(R3's) heels should be off-loaded. (R3's) pillows should not be under her heels.

On 6-27-24 at 1:35 PM V18 (Assistant Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF KNOX COUNTY	280 EAST LOSEY STREET GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 Nursing) stated, "(R3) does not have a care plan with pressure relieving interventions to address (R3) being at high risk of developing a pressure ulcer." On 6-27-24 at 1:45 PM V2 (Director of Nursing) stated, "(R3's) heels should be off-loaded when she is in bed. Pillows should be placed under (R3's) ankles and calves to keep (R3's) heels off of the bed. The pillows should not be placed under (R3's) heels as that does no good to relieve pressure." On 6-27-24 at 2:15 PM V15 (CNA) stated, "I do not elevate (R3's) heels off of the bed." (B)	S9999		