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	IL6009112	A. BUILDING: _____ B. WING _____	C 07/03/2024

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PAUL HOUSE & HEALTH CR CTR	3800 NORTH CALIFORNIA AVENUE CHICAGO, IL 60618

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S 000	Initial Comments Complaint Investigation 2484758/IL174479	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 300.1210 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	S9999		

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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:

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 were not met as evidenced by:

Based on interviews and record review, the facility failed to properly assess one resident (R1) for skin breakdown; and failed to prevent, recognize and treat a new wound that was acquired in the facility for 1 resident (R1) out of 7 residents reviewed for nursing care. This failure resulted in R1 being sent out to the hospital on 5/29/24 for altered mental status in which it was discovered R1 had a unstageable wound to the sacrum and again R1 was evaluated in the hospital on 6/5/24 where R1's sacral wound extended to the anus and required surgical debridement.

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Findings include:

R1 is an 83 year old with diagnosis including but not limited to: Muscle weakness, abnormalities of gait and balance, cognitive communication deficit, cerebral infarction, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side.

On 7/01/2024 at 10:10 AM, V1 (Administrator) said, "R1 has been discharged from the facility. He went to the hospital on 6/5/2024 and the family decided to take him home from the Hospital." (R1 was sent on 6/5/24 to the hospital for wound evaluation)

On 7/1/2024 at 10:15 AM, V6 (R1's family) said, "There have been times that I have gone to visit my dad (R1) and noticed that he smelled of urine and feces. He (R1) had a rash and wound on his scrotum. He (R1) had developed a wound on his back that spread to his anus. It was so deep that he had to have surgery and also had a colostomy bag placed. He (R1) had necrotic tissue that had to be removed and he also had formed infections in the wound. He (R1) is still not completely healed from the wound. My dad (R1) did not have any wounds when he was admitted to the facility on 4/26/2024 and now he (R1) has an unstageable wound from which he (R1) is having many complications. The facility didn't prevent my dad's pressure wound from forming and did not treat my dad (R1's) wound until it was too late. He (R1) developed the pressure ulcer in the facility, before he was even hospitalized. He (R1) then got a wound infection in the facility and went back out to the Hospital for the infection."

On 07/02/2024 at 1:12 PM, V14 (ADON/ Assistant Director of Nursing) said, "I help with

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wounds sometimes when the wound nurse is not here."

On 07/02/2024 at 1:12 PM, V14 said, "R1 was incontinent. He (R1) was not alert and oriented and will not call for help if he is wet. For incontinent patients, they are usually rounded on every two hours to reposition and change. I was not in the facility on the day that R1 was readmitted to the facility. I live close by, so I have no problems coming into the facility to assess a wound. I was not aware of R1's wound. I (V14) am not sure why the wound care orders were not entered until 6/2/2024 because he (R1) came back to the facility on 5/31/2024. I was not aware of R1 having any skin breakdown."

On 07/02/2024 at 1:12 PM, V14 (ADON) said, "If a patient has a wound upon admission, wound care team is notified to assess the patient and implement treatment. We (wound team) will call the Doctor to get orders for a wound to ensure that it is treated. A patient can have skin breakdown within 24 hours because the skin is very tender and older patients are more prone to skin breakdown. For wound prevention, we use air mattresses, zinc oxide to protect the skin and we reposition and change the patients every two hours. The wounds can quickly worsen without treatment. My expectation is that there are no wounds developed or worsening in this facility."

On 07/02/2024 at 1:14 PM, V14 (ADON) said, "There can be many complications from a pressure ulcer including: sepsis (blood infection) or skin infections such as cellulitis."

On 7/3/2024 at 1:50 PM, V18 (LPN/Licensed Practical Nurse) said, "I re-admitted R1 back to the facility. I don't recall any further orders for

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wound care at the time of R1's admission. I'm sure that I notified the nursing manager and I did document my findings of the open area on the skin. I am not sure what was done after that."

On 7/3/2024 at 2:24 PM, V19 (Nurse Practitioner) said, "If I saw the patent (R1) after re-admission to the facility, I would have definitely entered orders for wound treatment. Ideally, the nurse would call the primary Doctor and the wound care consult is ordered for assessment on the next day. The purpose of the treatment would be to heal the wound and to prevent it from worsening."

Facility Census report documents, R1 was admitted to the facility on 4/26/2024; R1 was admitted to the Hospital on 5/29/2024; R1 was re-admitted to the facility from the Hospital on 5/31/2024; R1 was discharged from the facility on 6/5/2024.

Facility Admission Summary note dated 4/26/2024 documents, head to toe assessment done with no skin issue noted.

Facility Admission Screener dated 4/26/2024 documents, R1 does not have impaired skin integrity upon admission.

R1's Interim Care Plan dated 4/26/2024 documents, R1 is at risk for altered skin integrity related to incontinence and decreased mobility.

R1's MDS (Minimum Data Set) - Section M dated 5/1/2024 documents, the resident (R1) is not at risk for developing pressure injuries/ulcers; the resident (R1) has no unhealed pressure injuries/ulcers.

R1's MDS (Minimum Data Set) - Section H dated

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5/1/2024 documents, R1 has occasional urinary and bowel incontinence; trial of a toileting program has not been attempted; No toileting program currently being used.

Hospital Emergency Department Nurse note dated 5/29/2024 and written by V17 (Hospital Nurse) documents, Patient (R1) has wound on the sacrum, partial thickness.

R1's (6/5/24) hospital record documents in part: R1 was sent for sacral wound evaluation. Wound measured 9 cm x 9 cm, base: moist, necrotic, extends to the anus.

Hospital Discharge instructions dated 5/31/2024 documents a new order for miconazole nitrate ointment.

Facility Nurse Progress note dated 5/31/2024 documents, body assessment completed, patient (R1) has open area on sacrum, dressing is covering the area, and R1 has noted irritation to penis area. Medical Doctor made aware R1 has returned. Orders are to stay the same.

Facility Admission Screener dated 5/31/2024 documents, R1 has impaired skin integrity upon admission (R1 was readmitted to the facility from the hospital).

R1's MDS (Minimum Data Set) - Section H dated 5/29/2024 documents, R1 is always incontinent.

R1's MDS (Minimum Data Set) - Section M dated 6/5/2024 documents, R1 has one or more unhealed pressure ulcers.

R1's Physician Order Summary Report documents wound care orders for treatment of

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buttock and sacrum entered on 6/2/2024; orders for LALM (Low Air Loss Mattress) entered on 6/3/2023; orders for treatment of perianal/ scrotum entered on 6/5/2024; turn and reposition orders entered on 6/5/2024; and order for wound cream entered on 6/5/2024.

R1's Physician Order Summary Report documents no order for miconazole nitrate ointment.

R1's Treatment Administration Record (TAR) documents, no treatments implemented for R1's wounds on 5/31/24, 6/1/24 or 6/2/2024. Hospital summary dated 6/12/2024 documents, R1 was seen for sacral wound cellulitis and osteomyelitis; R1 will also need a diverting colostomy, sharp excisional debridement of sacral decubitus on 6/7/2024, post operation day one.

Facility policy titled Pressure Ulcer Treatment and Management documents, Residents with pressure ulcers will have a physician's order for treatment; residents with pressure ulcers will be determined to be at high risk for pressure ulcer prevention and all components of the At Risk Protocol will include; pressure relieving devices, nutritional support, assistance with mobility including repositioning and ROM (range of motion) as outlined in the At Risk Protocol.

Facility policy titled Pressure Ulcer Prevention protocol documents, Daily skin checks conducted by either the CNA (Certified Nurse Assistance) or Licensed Nurse to ensure early identification of potential problem areas.

Facility policy titled Pressure Ulcer Risk Assessment documents, to implement a

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S9999	Continued From page 7 standardized plan of pressure ulcer prevention based upon a reliable and valid assessment of pressure ulcer risk. (B)	S9999		