STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007868	A. BUILDING: _____ B. WING _____	C 11/07/2024

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ELEVATE CARE SOUTH HOLLAND	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation 2498725/IL179857	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 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)

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:

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 regulations were not met as evidenced by:

Based on interview and record review, the facility

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failed to follow their physician notification of laboratory/radiology/diagnostic results policy by not notifying the physician/nurse practitioner of a sacral wound culture results indicating high amount of bacteria (greater than 100,000 pseudomonas aeruginosa) for one resident (R2) who had a stage three sacral pressure ulcer. This affected one of three (R2) residents reviewed for notification of an abnormal lab result. This failure resulted in R1 not receiving any antibiotic treatments and being hospitalized two weeks later with a diagnosis of sacral osteomyelitis.

Findings include:

R2 was admitted to the facility on 8/16/24 with a diagnosis of sepsis, pressure ulcer of sacral region stage three, quadriplegia, anemia, muscle wasting and adult failure to thrive.

R2's wound assessment dated 10/3/24 by V14 (Wound NP/Nurse Practitioner) documents: pressure injury stage three to coccyx measuring 5 centimeters (CM) length x 4CM width x 0.1cm depth. 60 % granulation and 40 % sloth. Signs and Symptoms of Infection: documents odor. Comments: obtain wound culture and labs, consult Infectious disease.

R2's progress note dated 10/3/24 documents, seen per wound MD (Medical Doctor) with coccyx assessed with positive malodor and onset green tinge to drainage, wound culture obtained, V17 (Infectious Disease/ID, NP) consult initiated, V17 (ID NP) notified.

On 11/1/24 at 11:28AM, V15 (previous Wound Care Coordinator) said she recalls R2's wounds declining and ordering wound culture. V15 said usually V17 (NP) will follow up with the results

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and order an appropriate treatment. V15 said she is not sure what happened and does not recall any other information related to R2's culture result. V15 said she does not recall informing or following up with anyone related to R2's wound culture results.

On 10/31/24 at 12:34PM, V17 (ID NP) said he did receive a message for consult on 10/3/24 but unsure why R2 was not seen. V17 said usually the ordering physician would be notified of culture results. V17 said he was not aware of R2's wound culture results and would have ordered antibiotics for R2.

On 10/30/24 at 2:55PM, V14 (previous Wound MD) said her last visit with R2 was on 10/3/24 and she did not return for any services at the facility. V14 said she ordered the wound culture due to wound declining and signs of infection. V14 did not receive any culture results for R2. V14 said at the facility they will consult Infectious Disease for further management to determine right antibiotic. V14 said she would usually follow up the next visit to see what antibiotic the patient was on or follow up with results. V14 said it is possible for the wound to get worse if there was an infection but unable to determine exact cause of infection.

R2's facility wound assessment report dated 10/4/24 documents: stage 3 pressure ulcer. Under odor and signs of infection present it documents yes.

R2's wound care note dated 10/11/24 by V13 (Wound NP) documents sacral pressure ulcer stage 4 measuring 8 centimeters (CM) length x 8.5 cm width x 2 cm depth. Necrotic tissue 90% slough 10%. wound debrided post debridement

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size measuring 8 centimeters (CM) length x 8.5 cm width x 2.3 cm depth.

On 10/30/24 at 1:32PM, V13 (Wound MD) said his initial visit of R2 was on 10/11/24. V13 said he was not notified of any culture results for R2 at time of visit or after.

On 10/31/24 at 1:28PM, V2 (DON/Director of Nurses) said for wound culture orders, the wound care nurse would obtain culture and send out to the lab. Floor nurse would receive the results and relay the results to primary care physician who would determine any orders. On 10/31/24 at 2:15PM, V2 (DON) said she did receive an email for R2's culture result but unsure what happened with the follow up.

On 11/1/24 at 11:44AM, V19 (MD) said he does not recall getting notified of wound culture results for R2. Usually, the ordering physician is notified of the results, but staff should always call him with any results. If there was a need for treatment V19 said he would have ordered the appropriate antibiotics but sometimes the culture can be colonized, and treatment is not needed. Osteomyelitis can occur from the wound progression and infection. R2's development of osteomyelitis can be a combination of both infection and declining wound status and unable to determine the exact cause. V19 said there should have been sooner intervention in relation to the wound culture results but unable to determine if the interventions were placed if R2 would have not gotten osteomyelitis given the overall wound progression.

R2's medical record under lab results documents wound culture collected 10/3/24, reported date 10/7/24 with reviewed status. Wound pathogen

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panel dated 10/7/24 documents: pseudomonas aeruginosa, staphylococcus aureus and streptococcus agalactiae detected. Positive. Printed 10/11/24.

R2's final lab report dated 10/7/24 documents: coccyx wound culture results indicating high amount of bacteria greater than 100,000 of pseudomonas aeruginosa. V14(previous Wound NP) is listed as physician.

On 11/1/24 at 9:04AM, V18 (Lab Director of Operations) said results were sent to facility on 10/7/24 but the whole report did not send. V18 said the full results were emailed to the facility on 10/7/24. V18 said they will recommend treatment for any result indicating high.

R2's progress note dated 10/25/24: seen per wound MD with coccyx assessed, bedside debridement performed to promote wound healing, malodor persists.

R2' medication administration record and physician orders did not document any new antibiotic treatment after 10/7/24 -10/26/24.

R2's braden score dated 9/15/24 documents a score of 13 which indicates moderate risk for skin breakdown.

R2's hospital record dated 10/26/24 documents under diagnosis: Sacral osteomyelitis.

R2's facility wound assessment reports dated 10/15/24 and 10/22/24 documents under odor: yes, signs of infection present: yes.

R2's plan of care initiated 8/19/24 documents: R2 has pressure injury to coccyx, is at risk for

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S9999	Continued From page 6 delayed wound healing and is at risk for further alteration in skin integrity related to immobility muscle wasting, quadriplegia, R2 has history of sepsis, anxiety asthma, fever, bedbound, wounds present on admission. Varied compliance with repositioning. Limited tissue perfusion at the point of pressure immobility and infrequent offloading. Adult failure to thrive and skin failure. Interventions include: monitor for signs and symptoms of infection (redness, warmth, swelling, pain, excessive drainage, odor) and notify provider. Date Initiated: 08/20/2024 ; Ongoing assessment of wound to evaluate signs of deterioration or improvement and possible change of treatment. Date Initiated: 08/20/2024. Facility policy Physician notification of laboratory/radiology/diagnostic results revised 7/8/24 documents: to assure the physician ordered tests are performed, and to assure test results are reported to the ordering physician so that prompt, appropriate action may be taken if indicated for the residents care. A nurse is responsible for monitoring the receipt of test results. Test results should be reported to the primary care physician or other ordering practitioner. In the event a physician does not respond promptly the alternative physician or medical director will be notified. (A)	S9999		