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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.1220b)3) 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. 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.	S9999		

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 services to promote healing, prevent infection, and prevent new pressure sores from developing.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's

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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.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents who developed facility-acquired pressure ulcers were assessed by the wound care physician/NP-Nurse Practitioner; failed to ensure the residents received nutritional interventions to promote wound healing; failed to put interventions in place to prevent pressure ulcers from deteriorating; failed to provide wound care treatments as ordered by the physician; and failed to follow their policy to do a root cause analysis for residents with facility-acquired pressure ulcers.

This failures resulted in R1's facility-acquired pressure ulcer increasing in size, and R1's DTI (Deep Tissue Injury) progressing to an unstageable pressure ulcer. This applies to 3 of 3 residents (R1, R2, R3) reviewed for facility-acquired pressure ulcers in the sample of 3.

The findings include:

1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on September 24, 2024 with multiple diagnoses including

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nondisplaced fracture of the right great toe, COPD (Chronic Obstructive Pulmonary Disease), OSA (Obstructive Sleep Apnea), Type 2 diabetes, cataract, hypertension, lymphedema, history of breast cancer, heart failure, morbid obesity, altered mental status, major depressive disorder, insomnia, muscle weakness, difficulty walking, lack of coordination, need for assistance with personal care, shortness of breath, and dementia.

R1's MDS (Minimum Data Set) dated October 17, 2024 shows R1 has moderate cognitive impairment, requires setup assistance with eating, supervision with oral and personal hygiene, bed mobility, and transfers between surfaces, and substantial/maximal assistance with toilet hygiene, showering, and lower body dressing. R1 is occasionally incontinent of urine, and frequently incontinent of stool. The MDS continues to show R1 was at risk of developing pressure ulcers and did not have pressure ulcers at the time of her admission to the facility.

On November 25, 2024 at 10:26 PM, V11 (Nurse) documented, "Writer made aware of open area to heel left foot. Upon further assessment, writer observed open area on left heel. Writer cleaned area with normal saline, dried with sterile gauze and applied 4x4 to area. Provider and family is aware. Wound care is aware. New orders for protein and to keep foot elevated and Podiatry consult. Staff to continue to follow up."

On November 26, 2024 at 9:40 AM, V3 (WCN/RN) documented, "Was notified that a wound was found on [R1's] left heel. Upon assessment, she has a Stage 3 pressure ulcer there. She was also found to have a small DTI (Deep Tissue Injury) on her right heel. She

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spends little time in bed, but she may have pressure from the back of her shoes. Her daughter and MD were notified."

On November 25, 2024 at 1:40 PM, V1 (Administrator) documented, "I saw [R1] at lunch time propelling herself to the dining room using her heels. I asked [R1] if she wanted help, she stated no she was fine."

On December 4, 2024 at 9:15 AM, R1 was lying in bed in her room, sleeping. R1 was not covered by a sheet or blanket and her legs were visible. R1's heels were resting on the mattress. R1 was not wearing foam heel boots. No pillows were present in R1's bed to offload her heels from the mattress. R1 did not have a low air loss mattress.

On December 4, 2024 at 9:28 AM, V10 (CNA-Certified Nursing Assistant) entered R1's room and said, "I had to wake her up this morning. She likes to sleep late." R1 attempted to make position changes in her bed but found it difficult to change positions in bed without the assistance of V10. V10 was unable to find foam heel boots or other pillows in R1's room to elevate R1's heels off the bed. R1 was wearing a nightgown and short socks in bed. V10 removed R1's socks. R1 had a dressing over the back of her left heel. The dressing had peeled away from R1's skin and was bunched up over the back of her ankle. The wound on R1's heel was exposed. The wound on R1's heel appeared approximately 1 inch in diameter. The wound appeared crater-like, dry, and with some redness in the center of the wound. R1 also had a dressing over her right heel, and the wound was not visible. V10 assisted R1 with dressing herself and placed R1's shoes on her feet.

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On December 4, 2024 at 9:40 AM, V3 (WCN-Wound Care Nurse/RN-Registered Nurse) said she believes R1's pressure ulcers were caused by R1's shoes. V3 said, "[R1] uses her feet to propel herself around in her wheelchair. She has a Stage 3 pressure ulcer on her left heel and a DTI (Deep Tissue Injury) on her right heel. Both wounds were found on November 26, 2024. We have two wound NPs (Nurse Practitioners) who come to the facility weekly. [R1] has not been seen by either wound care NP. I don't think we have a protocol for when the residents should be seen by the wound care NP. I don't think we have a protocol for when residents should be put on a low air loss mattress. Usually, we only use a low air loss mattress when the resident is immobile and has a Stage 2 or higher pressure ulcer." V3 entered R1's room at 9:45 AM. R1 was sitting up in her wheelchair fully dressed, including wearing her shoes. V3 told R1 she was surprised to see R1 wearing her shoes. V3 removed the dressing on R1's left heel. V3 noted the dressing was not covering R1's pressure ulcer. V3 said the dressing should be covering R1's pressure ulcer. V3 said, "On November 26, 2024, R1's left heel wound measurements were 1.2 cm. (centimeters) long by 0.8 cm. wide, by 0.3 cm. deep. Today the measurements are 1.5 cm. long by 1.8 cm. wide, by 0.2 cm. deep. The wound is getting wider/bigger." V3 removed the dressing on R1's right heel and said, "The DTI area has now turned to a scab. I am going to discontinue putting any dressing on this and leave it open to air." During the wound care treatment, R1 stated she has very little feeling in her feet due to her diabetes. R1 said she can feel something is there but could not say exactly what she was feeling.

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On December 4, 2024 at 11:26 AM, V8 (WCN/LPN-Licensed Practical Nurse) said, "I am responsible for arranging all wound care visits between our wound care providers and the residents. The other wound care nurses notify me who needs to be seen and I arrange it. The wound care physician and NPs come to the facility on Mondays and Tuesdays, and I round with them. We were never notified [R1] needed to be seen by the wound care physician or NP, so we did not see that resident. It could have happened right away if [V3] (WCN/RN) would have made the referral and added [R1] to the list." V8 continued to say when a resident has a DTI and the DTI develops a scab over the area, the pressure ulcer would be considered an unstageable pressure ulcer.

As of December 5, 2024 at 4:00 PM, the facility did not have documentation to show R1 was assessed by the wound care physician or NP since the development of her pressure ulcer on November 25, 2024.

The facility does not have documentation to show R1 was encouraged not to wear her shoes or to stop using her heels to self-propel her wheelchair. The facility does not have documentation to show R1 was educated regarding her pressure ulcers.

The facility does not have documentation to show R1 was assessed by the dietitian following the development of her pressure ulcers until December 4, 2024. V5 (Dietitian) documented R1 has "Increased protein needs related to increased demand for healing as evidenced by skin impairments." The facility does not have documentation to show orders for protein supplements were ordered until December 4, 2024.

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R1's care plan for potential for pressure ulcer development/impaired skin integrity was created on September 24, 2024 by V12 (MDS Nurse). R1's care plan does not show R1's care plan interventions were updated after the development of her left heel Stage 3 pressure ulcer, or her right heel DTI.

On December 4, 2024 at 3:24 PM, V12 (MDS Nurse) said, "I was aware [R1] developed pressure ulcers. I did not update the care plan interventions. [R1's] care plan interventions were not updated after she developed pressure ulcers."

The facility does not have documentation to show a root cause analysis was completed after R1 developed pressure ulcers at the facility, as shown in the facility's policy for facility-acquired pressure ulcers.

On December 4, 2024 at 3:24 PM, V9 (NP) said, "I was aware [R1] developed pressure ulcers. I believe they automatically have the wound NP look at the resident. I usually just have the wound care nurse address it unless it gets worse. Then we must take more invasive steps. I was not notified that [R1's] wound was larger as of today. The wound nurse told me the shoes were rubbing on her heel. It would be my expectation that they put interventions in place to prevent the wound from getting worse."

On December 4, 2024 at 4:17 PM, V13 (Primary Care Physician) said, "The last time I saw [R1] was October 22, 2024. I was called and told [R1] had a pressure ulcer last week. They told me it was because of the shoes she was wearing. Of course, I would expect them to stop putting those

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shoes on her if that is what caused the pressure ulcers. I would have expected them to have her seen by the wound care doctor or nurse practitioner, and make sure she was evaluated by the dietitian. If she had a DTI and it now has a scab on it, that wound is considered an unstageable pressure ulcer, so that wound is worse. If the Stage 3 pressure ulcer measurements are bigger, then that wound got worse also. Of course, they should put new interventions in place once they find someone has a pressure ulcer. I would say her pressure ulcers got worse because they did not do anything to prevent that from happening."

2. The EMR shows R2 was admitted to the facility on October 29, 2024. R2 has multiple diagnoses including, right lower limb cellulitis, chronic lymphocytic leukemia, dementia, muscle weakness, difficulty walking, falls, idiopathic neuropathy, atrial fibrillation, acquired absence of right toe, and major depressive disorder.

R2's MDS dated November 5, 2024 shows R2 is cognitively intact, requires supervision with eating, partial/moderate assistance with oral hygiene, bed mobility, and transfers between surfaces, substantial/maximal assistance with personal hygiene, and is dependent on facility staff for toilet hygiene, showering, and dressing. R2 is frequently incontinent of bowel and bladder. R2's MDS continues to show R2 was at risk for developing pressure ulcers and did not have any pressure ulcers at the time of the MDS assessment.

The facility's wound report dated December 4, 2024 at 10:22 AM shows R2 developed a facility acquired deep tissue pressure injury to his anterior left malleolus on November 20, 2024,

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and a facility-acquired unstageable pressure ulcer to his right heel.

The facility does not have documentation to show a care plan was initiated after R2 developed a facility-acquired pressure ulcer.

On December 4, 2024 at 3:40 PM, R2 was sitting up in his wheelchair in his room. R2 had a dressing on his right foot. R2 had difficulty answering questions about his wound due to his cognitive status at the time.

On December 5, 2024 at 12:33 PM, R2 was sitting up in his wheelchair in his room. R2 was wearing non-skid socks. Two visitors were present in the room and R2 did not want to be disturbed at that time.

On December 4, 2024 at 2:29 PM, V12 (MDS Nurse) said R2 does not have a care plan or interventions in place for his facility-acquired pressure ulcers.

The facility does not have documentation to show a root cause analysis was completed to determine the cause of R2's facility-acquired pressure ulcers as shown in the facility's policy.

The EMR shows the following order for R2 dated November 22, 2024: Right heel cleanse with house stock wound cleanser. Paint/swab with betadine and cover with dry dressing three times per week and as needed. The facility does not have documentation to show R2's wound treatments were administered as ordered on November 25, 27, and 29, 2024.

The EMR shows the following order for R2 dated November 22, 2024: Left malleolus anterior,

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cleanse with house stock wound cleanser. Paint/swab with betadine and cover with dry dressing three times per week and as needed, every Monday, Wednesday, Friday. The facility does not have documentation to show R2's wound treatments were administered as ordered on November 25, 27, 29, 2024.

On December 5, 2024 at 12:33 PM, V15 (Physician) said, "[R2's] debility puts him at an increased risk for the pressure ulcers. It is standard protocol to initiate interventions to prevent pressure ulcers. It is my expectation that wound care treatments be administered as ordered."

3. The EMR shows R3 was admitted to the facility on September 28, 2023 with multiple diagnoses including, idiopathic progressive neuropathy, Alzheimer's disease, major depressive disorder, personal history of cerebral infarction, history of breast cancer, and hypertension.

R3's MDS dated November 1, 2024 shows R3 has moderate cognitive impairment, requires supervision with eating and oral hygiene, substantial/maximal assistance with showering, personal hygiene, and bed mobility, and is dependent on facility staff for toilet hygiene, lower body dressing and transferring to and from the bed to the chair. R3 is always incontinent of bowel and bladder. R3's MDS continues to show R3 is at risk for developing pressure ulcers and did not have any pressure ulcers at the time of the MDS assessment.

On October 9, 2024 at 1:54 PM, V3 (WCN/RN) documented R3 had a facility-acquired Stage 2 pressure ulcer of the sacrum. The pressure ulcer

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measurements were 1.70 cm. long by 1.20 cm. wide by 0.10 cm. deep. Wound status: active.

On October 16, 2024 at 9:10 AM, V3 (WCN/RN) documented R3 had a Stage 2 pressure ulcer of the sacrum. The pressure ulcer measurements were 0.00 cm. long by 0.00 cm. wide by 0.00 cm. deep. Wound status: closed. V3's documentation continues to show, "The wound to [R3's] sacrum has closed. She reports intermittent pain in the area relieved with position changes. Wound care provided, tolerated well."

On October 24, 2024 at 10:07 AM, V3 (WCN/RN) documented R3 had a Stage 2 pressure ulcer of the sacrum. The pressure ulcer measurements were 0.00 cm. long by 0.00 cm. wide by 0.00 cm. deep. Wound status: closed. V3's documentation continues to show, "[R3] continues with small open area noted to her sacrum. She reports intermittent pain in the area relieved with position changes. Wound care performed, tolerated well." V3's documentation does not show the measurements for R3's open wound.

On November 4, 2024 at 9:59 AM, V3 (WCN/RN) documented R3 had a Stage 2 pressure ulcer of the sacrum. The pressure ulcer measurements were 0.00 cm. long by 0.00 cm. wide by 0.00 cm. deep. Wound status: closed. V3's documentation continues to show, "[R3] continues with wound area noted to her sacrum. She reports intermittent pain in the area relieved with position changes. Wound care performed, tolerated well." V3's documentation does not show the measurements for R3's wound area.

On November 13, 2024 at 10:54 AM, V3 (WCN/RN) documented R3 had a Stage 2

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pressure ulcer of the sacrum. The pressure ulcer measurements were 0.00 cm. long by 0.00 cm. wide by 0.00 cm. deep. Wound status: closed. V3's documentation continues to show, "[R3] continues with some redness to her sacrum ..." V3's documentation does not show the measurements for R3's reddened area.

On November 21, 2024 at 9:22 AM, V3 (WCN/RN) documented R3 had a Stage 2 pressure ulcer of the sacrum. The pressure ulcer measurements were 1.80 cm. long by 1.00 cm. wide by 0.00 cm. deep. Wound status: active. V3's documentation continues to show, "[R3] continues with open area noted to her sacrum. She reports intermittent pain in the area relieved with position changes. She is resistant to being on her side and spends much of her time on her back, not allowing this wound to improve much. She was left on her side after this visit. Wound care performed, tolerated well."

R3's care plans were reviewed. As of December 4, 2024, the facility did not have documentation to show a care plan was initiated following the development of the facility-acquired pressure ulcer on October 9, 2024.

The facility does not have documentation to show a root cause analysis was completed to determine the cause of R3's facility-acquired pressure ulcers as shown in the facility's policy.

The EMR shows the following order for R3 dated October 18, 2024 and discontinued on November 13, 2024: Wound care to sacrum. Cleanse with normal saline, pat dry, apply triad to wound area and cover with dry dressing three times weekly and as needed if dressing becomes soiled, every Monday, Wednesday, Friday. The facility does

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	IL6016281	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR - LAGRANGE	339 9TH AVENUE LA GRANGE, IL 60525

(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	S9999		

not have documentation to show the wound treatment was administered as ordered on, October 18, 21, 23, 25, 28, 30, 2024, and November 1, 6, 8, 11, 13, 2024.

The EMR shows the following order for R3 dated November 14, 2024: Wound care to sacrum. Cleanse with normal saline, pat dry and apply hydrocolloid dressing two times weekly and as needed if dressing becomes soiled or dislodged every Monday, Thursday. The facility does not have documentation to show the wound treatment was administered as ordered on November 28, 2024 or December 2, 2024.

On December 4, 2024 at 9:15 AM, R3 was lying in bed. R3 refused to get out of bed and stated she had a "sore butt."

On December 5, 2024 at 2:13 PM, V2 (DON-Director of Nursing) said she was confused by V3's (WCN/RN) documentation of R3's wounds. V2 confirmed V3's documentation showed the wound was closed on October 24, 2024 but later in her documentation V3 documented the wound was open and no measurements were documented. V2 also confirmed on November 4, 2024, V3 documented R3's wound was closed but then documented a wound area was noted to R3's sacrum and no measurements were documented. V2 (DON) said, "[V3's] (WCN/RN) documentation is inconsistent and does not make sense. [R3] had active orders for wound care treatments. Those treatments were not documented as being administered as ordered. Every resident who has a pressure ulcer should be referred to the wound care doctor/NP. That did not happen for [R1] and [R3]. Every resident who develops a pressure ulcer in the facility should have a root cause

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S9999	Continued From page 14	S9999		

analysis completed so we can individualize their care. That is our policy. That did not happen for [R1], [R2], and [R3]. All residents with pressure ulcers should have their nutrition assessed by the dietitian to see if they need protein supplements for wound healing. That did not happen either. We have three wound care nurses who work here and are exclusively assigned to wound care, seven days a week. Plus, we have two wound care doctors who visit this facility, twice a week. None of this should have happened."

The facility's policy entitled Skin Management: Dressing Application, revised on "10/16" shows: "General: Dressings are changed as ordered by the physician or NP. Guideline: ...8. Dress wound as directed in the physician orders. ...11. Document on treatment sheet that dressing was completed, measure and describe wound weekly, and document any pertinent findings or communication with physician/nurse practitioner in the medical record."

The facility's policy entitled Skin Management: Pressure ulcer, lower extremity ulcer evaluation and documentation, revised "7/14" shows: "General: To report and gather data for the purpose of planning and implementing wound care treatment procedures. To evaluate outcomes in terms of wound management. Responsible Party: Wound Care Team. Guideline: ...4. Pressure ulcers will be evaluated, a picture taken, and the following areas documented weekly: Location, Stage, Size: perpendicular measurement of the greatest extent of length and width of the ulcer using a disposable measuring device. Depth, presence and location. ...10. Wounds will be measured on a weekly basis ...."

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S9999	Continued From page 15 The facility's policy entitled, Unavoidable Evaluation, reviewed "10/16" shows: "Guideline: To provide a process for reviewing a pressure ulcer to determine the root cause. Responsible Party: Wound Care Team. Guideline: 1. When a resident develops an in house acquired pressure ulcer or the pressure ulcer deteriorates, the facility will do a root cause analysis to determine the reason. ...7. Once the evaluation is completed, the facility will consult with the physician and determine if the wound was unavoidable. If the resident's wound was unavoidable the physician will be asked to document such in the medical record." (B)	S9999		