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S 000	Initial Comments Complaint Investigation 2488208/IL179081 2488575/IL179628	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	S9999		

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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 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.

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These requirements were not met as evidenced by:

Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that staff are aware of required LALM (Low Air Loss Mattress) settings, failed to ensure that LALM checks were conducted, failed to ensure the LALM is on the correct setting/mode, failed to implement care plan interventions, failed to turn/reposition dependent residents every 2 hours, failed to ensure that wound assessments were accurate & staged correctly, failed to follow physician orders, and/or failed to ensure that treatments were administered as ordered for four of four residents (R1, R2, R3, R4) reviewed for pressure ulcers. These failures resulted in R1 sustaining a (facility acquired) infected large sacrum decubitus which required surgical intervention and osteomyelitis (bone infection) of the sacrum/coccyx. These failures also resulted in R3's (stage 3) sacrum pressure ulcer declining to (stage 4).

Findings include:

1. On 10/8/24 and 10/18/24, IDPH (Illinois Department of Public Health) received allegations that the facility failed to provide timely/adequate care to prevent stage 4 wounds. (R1) sustained a stage 4 infected wound that required surgery. R1's wound was down to the bone.

R1's diagnoses include but not limited to obesity, generalized muscle weakness, hypertensive heart disease, and congestive heart failure.

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R1 was admitted 12/22/23 transferred to the hospital on 9/21/24 and did not return to the facility.

R1's (12/22/23) risk for skin integrity impairment assessment determined a score of 12 (High Risk).

R1's (9/13/24) functional assessment affirms resident is dependent on staff for toileting hygiene and requires substantial/maximal assistance for rolling left and right (turning/repositioning).

R1's care plan includes (12/25/23) Resident has alteration of bowel & bladder functioning due to weakness and decreased mobility. (9/16/24) MASD (Moisture Associated Skin Damage) sacrum area. Interventions: perform skin at risk assessment per facility protocol. Notify MD (Medical Doctor) of significant changes. Identify potential causative factors and eliminate/ resolve when possible. Keep skin clean and dry. Turn and reposition every 2 hours.

On 10/28/24 at 1:05pm, surveyor inquired about R1's (facility acquired) skin integrity impairment, V2 (Director of Nursing) presented R1's (2/23/24) initial skin alteration record and (3/21/24) weekly skin alteration record and stated "2/23 is when the MASD started and 3/21 is when the MASD got resolved. Then, the 9/16 (2024) MASD was identified next."

R1's (9/16/24) initial skin alteration record states sacrum MASD. 7 x 4.5 x 0cm (centimeters). Wound margins/edges: erythema (redness). Peri -wound area erythema, warm to touch, cracked/excoriation. No pain verbalized or observed during treatment. Assist to reposition totally dependent. Preventive measures daily

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skin checks during CNA routine rounds, reposition every 2 hours and PRN (as needed), moisture barrier, incontinence care.

R1's POS (Physician Order Sheets) include (3/7/24) Air loss mattress checks for function every shift. Turn and reposition every 2 hours. (9/16/24) Medihoney apply to sacrum daily for excoriating/MASD. Cover with foam dressing.

R1's (9/16/24) progress notes state "wound care provided."

R1's (September 2024) TAR (Treatment Administration Record) affirms Medihoney to sacrum was not documented (blank spaces noted) on 9/17, 9/18, 9/19, 9/20, and 9/21 (5 days).

R1's (9/13/24) BIMS (Brief Interview Mental Status) determined a score of 12 (cognition intact).

R1's (9/21/24) ER (Emergency Room) progress notes state patient herself reports pain in her "butt" with pressure ulcer noted to her sacrum. Dressed with white substance and dressing on arrival [Medihoney which was prescribed - is not a white substance].
R1's (9/21/24) history and physical states patient presents to ER, patient is complaining of butt pain. Musculoskeletal: positive for back pain. Skin: Findings: Lesion present. Comments: Large sacral decubitus. Patient does endorse back pain near butt. Patient has large sacral decubitus. Differential diagnosis includes infection.

R1's surgical consults state (9/24/24) wound appears likely to involve muscle and likely

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periostium (membranous tissue that covers the surface of bone). Recommend MRI (Magnetic Resonance Imaging) to evaluate bone involvement. (9/26/24) Patient was noted to have sacral decubitus ulcer on admission with imaging/MRI (Magnetic Resonance Imaging) confirming osteomyelitis of the sacrum and coccyx. Seen by surgery and plan for debridement today.

R1's (10/3/24) discharge summary states wound cultures resulted pseudomonas (Bacteria) and VRE (Vancomycin-Resistant Enterococci) faecium (Bacteria).

On 10/28/24, surveyor requested credentials for the facility Wound Care Nurse. At 12:05pm, V1 (Administrator) stated that the facility employs two wound care Nurses (V8 & V10) however only presented V10's (Wound Care Nurse) wound care certification. Surveyor inquired when V10 was hired V1 responded "He (V10) started last Monday so that would be on October 21st" [7 days prior].

On 10/28/24 at 12:47pm, V1 stated that (V8/Wound Care Nurse) "Does not have wound care certification" and subsequently affirmed in writing that V8 does not possess the WCC (Wound Care Certified) certification. This employee (V8) was hired on September 18, 2023 (over 1 year ago).

On 10/29/24 at 12:11pm, surveyor inquired who's responsible for wound care at the facility V11 (ADON/Assistant Director of Nursing) stated "I troubleshoot for the facility just to do the dressing when the wound care is not here" and affirmed that when V8 (Wound Care Nurse) is not working she (V11) provides wound care. Surveyor

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inquired when V8 works at the facility V11 responded "Friday, Saturday, Sunday and Monday." Surveyor inquired if V11 is wound care certified V11 replied "No, I'm not." Surveyor inquired about R1's cognitive and functional status V11 stated "She is bedridden. She's incontinent both of urine and stool. She's alert 2-3, she can tell you change me, or I have poop." Surveyor inquired about R1's skin integrity impairment (prior to 9/21/24) hospital transfer V11 responded she (R1) has excoriation because she is incontinent of urine and stool. Surveyor inquired what causes excoriation V11 replied "Urine and stool, urine is very corrosive and stool." Surveyor inquired what blank spaces on the TAR indicates V11 stated "That they didn't do anything." Surveyor inquired if R1's Medihoney treatment/dressing was documented on the (August 2024 TAR) V11 reviewed R1's EMR (Electronic Medical Records) and responded "Nobody sign it or it means it's not there 5 days, the blank one. The Nurses on the floor should be doing this." Surveyor advised that V11 affirmed that she (V11) and V8 were responsible for wound care (in prior statement) V11 replied "I (V11) know, but if I cannot do it, I told them (assigned Nurses) that they have to do it." Surveyor inquired about potential harm to a resident if skin integrity impairments are not treated (as ordered) V11 stated "Well, it will just deteriorate with the stool and urine there. You need to clean it and put another dressing."

On 10/30/24 at 12:59pm, surveyor inquired about staff requirements for resident change in condition re: sacrum Decubitus V14 (Medical Director) stated "I would expect that the staging is done properly, the dressing requirements are very clear in the wound care plan, and the offloading mechanisms such as the low air loss mattress is

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ordered, and as a Physician or in-house Nurse Practitioner, there's a rounding and we treat infection if there's infection." Surveyor inquired about potential harm to a resident if treatments are not administered as ordered V14 responded "So there is potential for serious harm, the wound can become infected, and the resident can become septic." Surveyor inquired how osteomyelitis occurs V14 replied "It is a progression of any skin or soft tissue infection or trauma, the deeper the wound goes there's muscle and facia. The deeper the wound goes; it can involve the bone and it can be an infection which is osteomyelitis."

On 10/30/24 at 1:32pm, V13 (Agency Licensed Practical Nurse) affirmed that she was assigned to R1 on 9/21/24. Surveyor inquired about R1's sacrum skin integrity impairment V13 stated "That I'm not too familiar with it because I know that someone is there doing wound care [R1's TAR affirms that wound care was not documented for 5 days]. I'm not sure what kind of wound that (R1) had." V13 affirmed that V15 (CNA/Certified Nursing Assistant) was also assigned to R1 on 9/21/24.

On 10/30/24 at 2:15pm, surveyor inquired about R1's sacrum wound, V15 (Certified Nursing Assistant) stated "When I changed her, (R1) had like a patch on her butt and we (staff) usually put the zinc on it, it was just red." Surveyor inquired if R1 reported pain V15 replied "She might say that she is uncomfortable, so we just turn her side to side."

2. R3's diagnoses include Parkinson's disease and reduced mobility.

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R3's (9/3/24) risk for skin integrity impairment assessment determined a score of 12 (high risk).

R3's (10/3/24) functional assessment affirms resident is dependent on staff for rolling left and right.

R3's (4/4/24) initial skin alteration record (admission) includes (stage 3) sacrum pressure ulcer.

R3's (10/24/24) weekly skin alteration record includes (stage 4) sacrum pressure ulcer [therefore wound declined].

R3's POS includes (4/5/24) turning and repositioning every 2 hours. (4/9/24) air loss mattress check function every shift. (7/23/34) Calcium Alginate apply to sacral daily for stage 4 pressure ulcer after cleansing with NSS (Normal Saline Solution) and cover with dry dressing.

R3's care plan includes (4/5/24) high risk for alteration in skin integrity, Interventions: identify potential causative factors and eliminate/resolve when possible. LALM (Low Air Loss Mattress) check for function every shift.

On 10/23/24 at 3:44pm, R3 was lying on a LALM, and the setting was on "static" mode (therefore providing a firm surface). Surveyor inquired about R3's current LALM settings V5 (RN/Registered Nurse) stated "Usually it's preset." Surveyor inquired what "static" mode means V5 responded "I'm not familiar with this machine." R3 was noted to be lying on a white flat sheet, a thick blue folded sheet (8 layers), and folded bath blanket (4 layers). V5 counted the layers beneath R3 (as requested) and affirmed that there were "13" excluding the brief (therefore

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a total of 14 layers placed beneath the buttocks). Surveyor relayed concerns with all the linens placed between R3 and the LALM V5 replied "It should only be one, otherwise this one (LALM) won't work." V5 then proceeded to cover R3 with the blanket and left the room, V5 did not remove any of the sheets and/or blanket beneath R3 at this time.

R3's (October 2024) TAR affirms for low air loss mattress checks (blank entries) were noted on 10/5, 10/6, 10/8, 10/19, 10/23, 10/24, 10/25, and 10/27. For Calcium Alginate treatments "9" is documented on 10/6, 10/14, 10/17, 10/20 and 10/28. For turning/repositioning every 2 hours blank spaces were noted on 10/3, 10/5, 10/6, 10/7, 10/8, 10/9, 10/19, 10/20, 10/23, 10/24, 10/25, 10/27 and 10/28.

On 10/29/24 at 12:45pm, surveyor inquired why "9" was documented on R3's (October 2024) TAR, V11 (ADON) stated "I don't know why they (Nurses) do this number nine. 10/6 (2024) it says done by wound nurse (referring to R3's progress notes). 10/8 says done by wound nurse. 10/14 says done by wound nurse. 10/20 is done by wound nurse. 10/24 will be done by wound nurse." Surveyor inquired if Nurses should be charting wound care for other staff "V11 responded "No, they have to chart when they are doing it, the dressing and everything. Surveyor inquired what mode the LALM should be in while a resident is lying in bed V11 replied "The mattress should just stay in alternating because that is where the cell is alternating, go up and go down the bed, so the patient should be floating in the mattress." Surveyor inquired if several linen layers were placed under R3's buttocks while lying on a LALM is the mattress effective V11 stated "No, it has to be one layer only because

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the air can go to the patients skin."

3. R4's diagnoses include Parkinson's disease, generalized muscle weakness, and protein calorie malnutrition.

R4's (10/12/24) Braden determined a score of 11 (high risk).

R4's (9/13/24) initial skin alteration record was signed on 9/15/24 (2 days after assessment). Site: Abdomen. Description: Sacral wound stage 4 [the description is incongruent with the site]. Preventive measures: redistribution mattress.

R4's (10/12/24) re-admission skin alteration record states site: abdomen. Description: sacral wound stage 4. [again, the description is incongruent with the site].

R4's (10/24/24) weekly skin alteration record states sacrum stage 3 [therefore back staged].

R4's (9/13/24) POS states cleanse sacral wound with NS, apply Alginate, cover with dry dressing daily and as needed.

R4's (October 2024) TAR affirms sacral treatment was not documented (blank entries) on 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/15, 10/17, 10/18, 10/19, and 10/22. Low air loss mattress checks were initiated on 10/24 (1.5 months after implementation).

On 10/23/24 at 3:55pm, inquired if R4 has a wound V6 (RN) stated "It's on the back, he (R4) was just turned by the CNA."

R4's (10/15/24) BIMS determined a score of 9

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S9999	Continued From page 11 (moderate impairment). On 10/23/24 at 3:57pm, surveyor inquired if R4's dressing was changed today R4 replied "Uh um" nodded his head no and affirmed that it was not. R4 was lying atop of a LALM, surveyor inquired about the current settings on R4's LALM, V6 (RN) stated "Unfortunately I (V6) was not told as to what setting he (R4) should be in. Right now, the setting is at 250 (pounds) I wound say" however R4 appeared to be about half that weight. Surveyor inquired how much R4 weighs R4 responded "122 pounds." Surveyor requested to inspect R4 at this time. V7 (Certified Nursing Assistant) removed R4's incontinence brief which was dry however a dressing was not present and white cream was noted on the open sacral wound. Surveyor inquired about R4's exposed wound, V6 replied "I see a wound on the tailbone, it is an open wound." Surveyor inquired what was on R4's (stage 4) sacrum wound V6 stated "Zinc oxide." Surveyor inquired if a dressing was supposed to be on R4's sacrum V6 responded "Yes." On 10/28/24 at 10:36am, surveyor inquired why R4's initial wound assessment states stage 4 and the current wound assessment states stage 3, V2 (Director of Nursing) stated "Good question." Surveyor inquired about staging wounds, V2 responded "When staging from a stage 4 going to a stage 3, if the wound is getting better by the week-by-week assessment of the wound nurse." Surveyor inquired if back staging of wounds is appropriate V2 replied "Don't we indicate if its progressing or getting better?" Surveyor inquired if V2 was familiar with staging wounds V2 stated "No." [The National Pressure Ulcer Advisory Panel advises against reverse staging of pressure ulcers, or bedsores, because it doesn't	S9999		

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accurately reflect the healing process].

On 10/29/24 at 1:07pm, surveyor inquired why R4's initial sacral wound assessment (dated 9/13/24) was documented/signed on 9/15 (3 days after admission). V11 (ADON) stated "(R4) was admitted on the 12th and the assessment was done the next day. When you do it on the day it will give you the day that you did the assessment. If I do the assessment today, I have to sign the assessment for today." Surveyor inquired about concerns with R4's (9/13/24) initial wound assessment, V11 responded "The site says abdomen how can you put abdomen when the site is sacrum."

4. R2's diagnoses include dementia, type II diabetes mellitus, protein calorie malnutrition, and generalized muscle weakness.

R2's (10/12/24) risk for skin integrity impairment assessment determined a score of 10 (high risk).

R2's (10/12/24) initial skin alteration record (admission) includes left buttock stage 4 pressure ulcer and sacrum MASD.

R2's (10/24/24) weekly skin alteration record includes sacrum stage 4 [incongruent with the initial assessment] and buttocks MASD [incongruent with the initial assessment].

On 10/29/24 at 12:28pm, V11 (ADON) affirmed that (V8/Wound Care Nurse) documented R2's (10/12/24) and (10/24/24) wound assessments. Surveyor inquired why R2's (10/12/24) initial wound assessment includes left buttock stage 4 (black/eschar tissue) however the (10/24/24) assessment (conducted 12 days later) states buttocks MASD, V11 stated " (R2) cannot have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009112	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL HOUSE & HEALTH CR CTR	3800 NORTH CALIFORNIA AVENUE CHICAGO, IL 60618

(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
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MASD because (R2) is not eating. That cannot be, you cannot come back and change that to MASD. Stage 4 cannot go back to MASD. The documentation was not entered properly."

R2's (10/23/24) POS states cleanse sacral 1/2 strength Dakins, pat dry, apply metrocream, cover with dry dressing daily.

R2's (October 2024) TAR affirms the sacral treatment was not documented (blank entry) on 10/26/24.

The (7/2023) low air loss mattress policy states the purpose is to provide features of a mattress support system that provides a flow of air to assist in managing the heat and humidity of the skin. Low air loss mattresses will be utilized for residents with stage III and IV pressure ulcers of the trunk as well as residents with multiple stage II pressure ulcers. The low air loss mattress will be checked on a regular basis to ensure that all cells of the mattress are functioning appropriately. Any resident on a low air loss mattress will have a single non-fitted sheet which may be used for assistance with repositioning.

The management of wounds policy (revised 12/31/23) states it is the policy of this facility to manage tissue load and improve tissue tolerance to pressure, friction, and shearing forces. This will be accomplished through the use of appropriate positioning practices, positioning devices, and support services. It is the policy of this facility to treat the wound according to the guidelines of the Agency for Healthcare Research and Quality (AHRQ), National Pressure Ulcer Advisory Panel, and current standards of clinical practice. According to the AHRQ, "Care of the ulcer itself involves debridement of necrotic

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S9999	Continued From page 14 tissue, cleansing of the wound at initial examination and at each dressing change, and using a dressing that keeps the ulcer bed continuously moist but the surrounding intact skin dry." The following policies and procedures will be utilized: wound cleansing policy and procedure and wound dressing policy and procedure. (A)	S9999		