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	IL6007942	A. BUILDING: _____ B. WING _____	C 01/07/2025

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S 000	Initial Comments Complaint Investigation: 24510297/IL182774	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)3)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 resident's comprehensive assessment, which	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

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

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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 failed to implement interventions to prevent the development of pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 7. This failure resulted in R1 developing facility acquired moisture associated skin damage to the buttocks, a stage 2 pressure ulcer to the Left Ischium, a stage 3 pressure ulcer to the Right Ischium, and a stage 3 pressure ulcer to the Sacrum.

Findings include:

R1's Admission Record documented an initial Admission Date of 12/8/22 and a readmission date of 10/5/24. Diagnoses listed include Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side, Type 2 Diabetes, Chronic Kidney Disease Stage 4 (Severe), Morbid Obesity, Epilepsy, and Aphasia.

R1's 12/11/24 Braden Scale for Predicting Pressure Ulcer Risk documented a score of 11, indicating R1 is at high risk for the development of pressure ulcers. R1's Minimum Data Set dated 10/11/24 documented that R1 is severely cognitively impaired to the extent that a Brief Mental Status Score could not be performed, was always incontinent of bowel and bladder, required substantial/maximal staff assistance for bed mobility, and was totally dependent on staff for transfers. The same MDS documents in Section M, Skin Conditions, that R1 is at risk for pressure

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ulcers/injuries and that R1 did not have any pressure ulcers/injuries. R1's Care Plan dated 12/8/24 documented a Focus area of, "Pressure Ulcers, sites: Left Ischium, Right Ischium, Coccyx," with corresponding interventions, "Repositioning every 2 hours and PRN (as needed)." The same Care Plan also documents a Focus area of "Potential for impaired skin integrity related to: Cognitive deficits, Decreased sensation, PVD (Peripheral Vascular Disease), DM (Diabetes Mellitus), hemiplegia right side, Impaired mobility, Incontinence." Documented interventions include "Monitor Incontinence" and "provide pericare."

R1's Wound Assessment and Plan Notes, authored by V6, Wound Care Nurse Practitioner, documented the following:
12/1/24: "Wound location: Bilateral Buttocks, MASD (Moisture Associated Skin Damage) Wound onset date, 11/28/24. Irritant Contact Dermatitis due to dual incontinence. Coccyx, pressure injury, stage 3. Wound onset date, 11/28/24."
12/10/24:"Wound location: Sacrum, pressure injury, stage 3. Declined. Wound onset date 11/28/24. Location changed (from Coccyx) to more accurately reflect current wound. Wound location: Bilateral Buttocks: Healed. Wound location: Left Ischium, pressure injury, stage 2. Onset date 12/10/24. Wound location: Right Ischium, pressure injury, stage 3. Onset date 12/10/24."

R1's Nurses Notes dated 12/11/24 at 10:30pm stated, "Resident not responding during care, lethargic. Resident had blood in urine and fever of 101.2. Sending resident to ER (Emergency Room) for evaluation and treatment. Power of Attorney and MD (Medical Doctor) aware."

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R1's (local hospital) ED (Emergency Department) Note, Physician, dated 12/11/24 documented, "It was brought to my attention that the family wanted the patient to stay locally. However, after reviewing the patients chart, the patient is noted to have elevated White (Blood Cell) Count of 19.3" and continues, "And white (blood) cells in the urine which may indicate sepsis with abnormality in other organs. I ordered Ceftriaxone and the family was informed that the patient willing to be transferred for a higher level of care (at a regional hospital). Assessment: Dehydration, severe. Hypernatremia. UTI (Urinary Tract infection)." A (Regional Hospital) Admitting Physician History and Physical Examination dated 12/12/24 documented, "62 year old female with a past history significant for Diabetes Type 2, Bilateral Carotid Stenosis, Hypertension, Seizure Disorder, PVD (Peripheral Vascular Disease) presented to (Regional Hospital) on 12/12/24 with Altered Mental Status. Assessment/Plan: Altered Mental Status,Hypernatremia, UTI, Sepsis present outside facility with respiratory rate of 25, Altered Mental Status, elevated White (Blood Cell) Count of 19.3, Sacral Decubitus Ulcer present on admission, AKI (Acute Kidney Injury) on CKD (Chronic Kidney Disease)."

On 12/26/24 at 9:20am, V4, R1's Power of Attorney, stated on 12/11/24, V2, Director of Nurses, calledV4 to state R1 had recently developed pressure areas, had experienced a deterioration in status, and the facility was sending R1 to hospital for treatment, where R1 was found to have a UTI. V4 stated she was told by V2 that R1's pressure wounds were Kennedy Ulcers, and V2 stated these were as a result of R1
being near the end of her life. V4 stated she does

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not believe this is accurate as R1 has since improved and has not been under hospice care. V4 stated V4 believed R1 developed pressure wounds due to not being repositioned and changed often enough, based on V4's history of working many years as a CNA (Certified Nursing Assistant). V4 stated as an example, V4 informed staff she wanted R1 get up to the wheelchair for meals, but when V4 visited, R1 often ate meals in bed. V4 stated staff told V4 that R1, "Was a fall risk, had to be transferred with a mechanical lift, and they did not have enough staff to be able to supervise her while up." V4 stated she felt the facility was leaving R1 in bed all day for staff convenience. V4 stated after R1 was discharged from the hospital on 12/18/24, V4 had R1 sent to a different facility, where R1's wounds and overall condition have improved.

On 12/27/24 at 9:35am, V9, CNA, stated she primarily works the 6am to 6pm shift. V9 stated incontinent residents on the 6:00pm to 6:00am shift are not being changed and repositioned often enough. V9 stated most mornings when V9 arrives, including the morning of 12/27/24, incontinent, confused residents are urine soaked, with dried brown rings on bed linens, and dried feces. V9 stated although there are supposed to be at least 3 CNAs and one nurse on the 6:00pm shift, at times there are 2 CNAs and one nurse, and such was the case the previous night. V9 stated when she has verbalized concern about care and staffing to Administration, she was told to call the corporate hotline to complain.

On 12/27/24 at 10:15am, V8, CNA, stated she primarily works the 6am to 6pm shift. V8 stated the facility definitely does not have enough CNAs on the 6pm to 6am shift. V8 stated when she begins her shift at 6:00am, confused incontinent

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residents are frequently urine soaked, with brown rings on linens, and dried feces. V8 stated R1 was always incontinent of both bowel and bladder and was unable to reposition herself. When asked about R1 developing pressure wounds, V8 stated, "She probably got them from not being turned and changed enough." V8 stated in regard to R1, "They just tried to turn her as best they could when they remembered and tried to keep her clean and dry."

On 1/2/25 at 11:40am, V12, CNA, stated she generally works the 6am shift but has also worked the 6pm shift as well. V12 stated both shifts are often short of CNAs. V12 stated when she started her shift that morning (1/2/25), several incontinent residents were soaked with urine and had odor and brown rings on linens due to the 6:00pm shift not changing them. V12 stated, "There are definitely issues with people not getting turned and changed every 2 hours." V12 stated on the 6:00pm shift, "They don't do bed checks like they are supposed to. Everybody is in bed by 8:00pm or 9:00pm, then they are to do bed checks at 11:00pm, 1:00am, 3:00am, and 5:00am. They always skip the 11:00pm bed check, they do a bed check at 1:00am, then they start getting people up at 4:30am, so technically there is only one bed check, at 1am. V12 said there are times when perineal care is not done when changing incontinent residents due to time constraints, incontinence briefs are changed but the perineal area is not cleansed. This is happening a lot, mostly to confused residents who can't tell anybody what is going on." In regard to R1, V12 stated, "She for sure did not get turned every two hours. She (urinated) a lot, but we did try to keep her dry, although she may not have got her perineal area cleaned." V12 stated R1's family wanted her to get up to the

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wheelchair for meals, and when she (V12) worked with R1, she got her up. V12 stated complaints to Administration about staffing and care, "Go nowhere. Nothing ever changes."

On 1/2/25 at 2:25pm, V2, Director of Nurses, stated as far as she is aware, all dependent incontinent residents are being changed, receive perineal care, and are repositioned every two hours, including on the 6:00pm shift, and she has not heard otherwise. V2 stated R1's family would not have been told R1 couldn't be gotten up due to being a fall risk or not having enough staff to supervise her as those statements would not be accurate. V2 stated R1 developed MASD (Moisture Associated Skin Damage) to both buttocks and a stage 3 pressure wound to the Coccyx on 11/28/24 and was therefore referred to V6. V2 stated R1 went on to develop a stage 3 pressure area to the Right Ischial Tuberosity and a stage 2 pressure area to the Left Ischial Tuberosity, both acquired on 12/10/24. V2 stated she assumed all of these pressure areas were Kennedy Ulcers, associated with tissue breakdown at the end of life. V2 stated R1's condition continued to deteriorate and she was sent to the hospital on 12/11/24 due to nausea and vomiting and change in mental status. V2 stated a Urinalysis obtained prior to the hospital admission showed evidence of UTI. V2 stated at some point in December 2024, V4 had told V1, Administrator, that R1 would not be returning to the facility after hospitalization.

On 1/3/24 at 10:15am, V1, Administrator, stated V4 came to the facility in December 2024, date unknown, to state that V4 did not believe that R1's wounds could have occurred that quickly and to that extent unless R1 was not being turned and changed frequently. V1 stated V4 said R1

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would therefore not be returning to the facility. V1 stated as far as she knew, R1 was being changed and turned. V1 stated she told V4 that her understanding was that R1's areas were Kennedy Ulcers.

On 1/3/24 at 11:05am, V6, Wound Care Nurse Practitioner, stated she evaluated R1 on 12/1/24 for facility acquired MASD to both buttocks, and a facility acquired stage 3 pressure wound to the Coccyx, both acquired 11/28/24. V6 stated she evaluated R1 again on 12/10/24, and found the MASD to the buttocks had resolved but R1 had a facility acquired stage 2 pressure area to the Left Ischium and a facility acquired stage 3 pressure area to the Right Ischium, both acquired 12/10/24. V6 stated on 12/10/24 the Coccyx wound had deteriorated to involve the entire Sacrum at a stage 3. V6 stated within December 2024, following R1's hospitalization, she resumed treating R1, at a different facility, and last evaluated R1 on 12/31/24. V6 stated all the pressure areas are now healing and R1's overall condition has improved. V6 stated she does not endorse the use of the term "Kennedy Ulcers," and would not say R1 is currently at the end of life. V6 stated overall at the time the pressure areas developed, R1's overall health was in decline. V6 stated residents should be repositioned "frequently to improve blood flow, but not necessarily every two hours, the time to reposition residents varies with each individual." V6 stated not being changed frequently and the perineum not being cleansed of urine and feces would be very damaging to the skin, probably more so than not being frequently repositioned.

An Incontinence Care Policy dated 5/16/22 documented," All incontinent residents will receive incontinence care in order to keep skin

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S9999	Continued From page 9 clean, dry, and free of irritation and/or odor. Incontinence care will be provided as required. 8. Wash all soiled skin areas and dry very well, especially between skin folds. 11. Change linen as needed." The facility policy titled "Skin Integrity Protocol" (undated) documents "Preventative Measures: 1. Turning, positioning and pressure redistribution {off-loading) will be utilized for all residents who have been identified of being at risk for developing pressure ulcers ... 3. Minimizing exposure to moisture." (B)	S9999		