STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/15/2025

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S 000	Initial Comments Complaint Survey #2510251/IL184119	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999		

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accident, injury or change in condition at the time of notification.

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.

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 interview and record review the facility failed to identify an area of pressure before becoming a stage 3, failed to have a wound evaluated by a wound care professional and

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failed to assess and document an area of skin breakdown. This applies to one of three residents (R1) reviewed for pressure in the sample of three. This failure resulted in R1 sustaining a stage 3 pressure ulcer with 90% slough and necrotic tissue to her sacrum.

The findings include:

The facility face sheet for R1 shows she was admitted to the facility on 9/13/24 with diagnoses to include spinal stenosis, Type 2 Diabetes Mellitus, abnormalities of gait and mobility and urge incontinence. The facility assessment dated 9/20/24 shows R1 to have severe cognitive impairment and requires maximal assistance with her activities of daily living. The same assessment shows R1 was admitted to the facility with a risk of developing a pressure injury but did not currently have any. The facility's electronic health record census tabs shows R1 was discharged to another facility on 12/3/24.

On 1/15/25 at 11:00 AM, V4, R1's Power of Attorney (POA) said her mother was at the facility for rehab after back surgery and then she was to be transferred to another facility for long term care. V4 said she was told by the facility staff that R1 had a stage 2 pressure injury to her sacrum. V4 said she was aware of the pressure injury and had asked for R1 to be seen by a wound care professional, but that had never happened. V4 said when R1 arrived at the new facility, that facility's wound care provider happened to be in the building, and saw R1 that day. V4 said the provider said there was no way the pressure injury was a stage 2 due to all the slough (devitalized tissue) that was present. V4 said the provider debrided the wound and it was determined to be a stage 4 pressure injury with a

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small amount of bone being visualized.

On 1/15/25 at 9:45 AM, V1 Administrator and V2 Director of Nursing said V2 was in charge of wound care when R1 was a resident in the facility. V2 said when a resident gets a new wound it is assessed by her and a treatment is ordered for the care. A wound care professional is contracted by the facility to see all wounds, but the day R1's wound was discovered, she was also diagnosed with COVID-19 and was placed on isolation. V2 said the wound care professional would not see her while she was on isolation for COVID-19. V2 then said that after R1 was off of isolation, it was the Thanksgiving holiday and the wound care professional was not working. V2 said she continued with treatment of the wound and did not feel the wound was getting worse and was improving. V2 said the wound was a stage 3 pressure injury when it was found. The wound was filled with slough. V2 said she tried to get R1 seen by the local wound care clinic but no appointments were available. V1 and V2 said R1's Physician was aware of the wound and had signed orders for the care of the wound.

On 1/15/25 at 10:09 AM, V3 Registered Nurse said R1 was being treated for a wound to her sacrum with daily dressing changes. V3 said R1 had some sort of wound to her sacrum area before but she could not recall what the issue was. V3 said when R1 was transferred to another facility the wound care orders were sent with her. V3 said R1 was not seen by the wound care professionals at the facility due to her having been diagnosed with COVID-19 and was on isolation for 10 days. V3 said the wound to the sacrum of R1 had a lot of slough present with a black center found. V3 said you could not see the bottom of the wound. V3 said at one point the

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daughter asked that her mother be placed back on a medication to help with overactive bladder due to large amounts of incontinence and her mothers bottom was getting very red and sore. V3 said she reached out to the Physician and an order was obtained for the medication. V3 said that was on 11/6/24 that she reached out to the Physician telling him R1 was having large amounts of urine incontinence and her sacrum was having breakdown.

On 1/15/25 at 12:25 PM, V5 Nurse Practitioner (NP) said she saw R1 one time while she was at the facility and she was not aware R1 had a pressure injury to her sacrum.

On 1/15/25 at 2:20 PM, V6 Medical Doctor (MD) said he does not recall R1 having a pressure injury to her sacrum and does not recall giving any orders for it. V6 said when he is notified of a new pressure injury he usually goes with the nurse to look at the wound. V6 said he does not have any notes showing he did this with R1. V6 said he expects the staff to assess the skin frequently and report to him any skin issues. V6 said debridement of the wound would help with allowing healthy tissue to grow and will prevent infections and other complications. V6 said he was not surprised R1 developed a pressure injury due to her age, recent back surgery, immobility, incontinence and having uncontrolled diabetes.

On 1/15/25 at 2:45 PM, V2 said she was not aware R1 had orders for wound care between 9/27/24 and 10/20/24 and feels it must have been for preventative measures for R1. V2 said she expects an area of pressure to be identified prior to it becoming a stage 3.

The facility pressure ulcer weekly wound

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evaluation form dated 11/11/24 shows R1 had a stage 2 facility acquired pressure ulcer to her sacrum with slough present and a moderate amount of drainage. The skin around the wound was labeled as macerated (skin softens and breaks down due to moisture). The date acquired was shown as 11/11/24. No measurements are recorded on this document.

The weekly pressure ulcer report dated 11/11/24 shows R1 had a stage 3 pressure ulcer first identified that day and measured 3.0 by 2.5 centimeters with an unknown depth to her sacrum. The wound was 90% slough filled. The note shows to refer to wound care professional once off isolation.
The weekly pressure ulcer report dated 11/18/24 shows the wound was measured at 2.9 by 2.5 centimeters and an unknown depth with 90% slough present.
The report dated 11/25/24 shows R1's wound was measured at 2.9 by 2.5 centimeters with a depth of 0.2 centimeters with slough still at 90%.
The report dated 12/2/24 the day before R1's discharge, shows the wound still had 90% slough and measured 2.8 by 2.0 centimeters.

The Physician Order Sheet (POS) shows an order dated 9/26/24 to cleanse the open area to sacral area with wound care cleanser, pat dry, apply medi honey to wound bed, cover with bordered foam dressing daily and as needed. The order shows it was entered by V2 DON.
The weekly pressure ulcer report dated 9/3024 does not show any open areas for R1.
The facility electronic health record for R1 does not show any evidence of an open area to R1's sacrum being measured or monitored from 9/27/24 to 10/20/24.
The facility Treatment Administration Record

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S9999	Continued From page 6 (TAR) dated 9/2024 and 10/2024 shows a dressing change was completed on R1 between 9/27/24 to 10/19/24. The TAR dated November 2024 shows R1 was on droplet precautions from 11/11/24 to 11/22/24 for a COVID-19 infection. A Physician communication form dated 11/6/24 shows R1 was having large amounts of urine incontinence and had breakdown to her sacral area. The office clinic notes dated 11/29/24 signed by V5 NP does not show any wounds for R1. The progress note dated 11/27/24 signed by V6 MD does not show any skin issues for R1. The facility policy with a revision date of 3/2021 for wound assessment shows it is the policy of the facility to assess each wound at the time the wound is identified. Each would will be assessed weekly thereafter or with any significant change in the wound. The wound policy also shows if the wound base is obscured by slough it is classified as an unstageable wound and the once the slough is removed a stage 3 or 4 ulcer will be revealed. (B)	S9999		